Volume XXI Number 4

THE SOCIAL SERVICE REVIEW

DECEMBER 1947

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THE UNIVERSITY OF CHICAGO PRESS
CHICAGO, ILLINOIS, U.S.A.

THE SOCIAL SERVICE REVIEW

A QUARTERLY DEVOTED TO THE SCIENTIFIC AND PROFESSIONAL INTERESTS OF SOCIAL WORK

The Social Service Review is published quarterly by the University of Chicago at the University Press, 5750 Ellis Avenue, Chicago, Ill. The subscription price is $5.00 per year; the price of single copies is $1.50. Orders for service of less than a full year will be charged at the single-copy rate. Postage is prepaid by the publishers on all orders from the United States and its possessions, Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, Guatemala, Haiti, Republic of Honduras, Mexico, Morocco (Spanish Zone), Nicaragua, Panama, Paraguay, Peru, Rio de Oro, El Salvador, Spain (including Balearic Islands, Canary Islands, and the Spanish Offices in northern Africa; Andorra), Spanish Guinea, Uruguay, and Venezuela. Postage is charged extra as follows: for Canada and Newfoundland, 20 cents on annual subscriptions (total $5.20), on single copies, 5 cents (total $1.55); for all other countries in the Postal Union, 48 cents on annual subscriptions (total $5.48), on single copies, 12 cents (total $1.62). Patrons are requested to make all remittances payable to The University of Chicago Press in United States currency or its equivalent by postal or express money orders or bank drafts.

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Claims for missing numbers should be made within the month following the regular month of publication. The publishers expect to supply missing numbers free only when losses have been sustained in transit and when the reserve stock will permit.

Business correspondence should be addressed to The University of Chicago Press, Chicago 37, Ill.

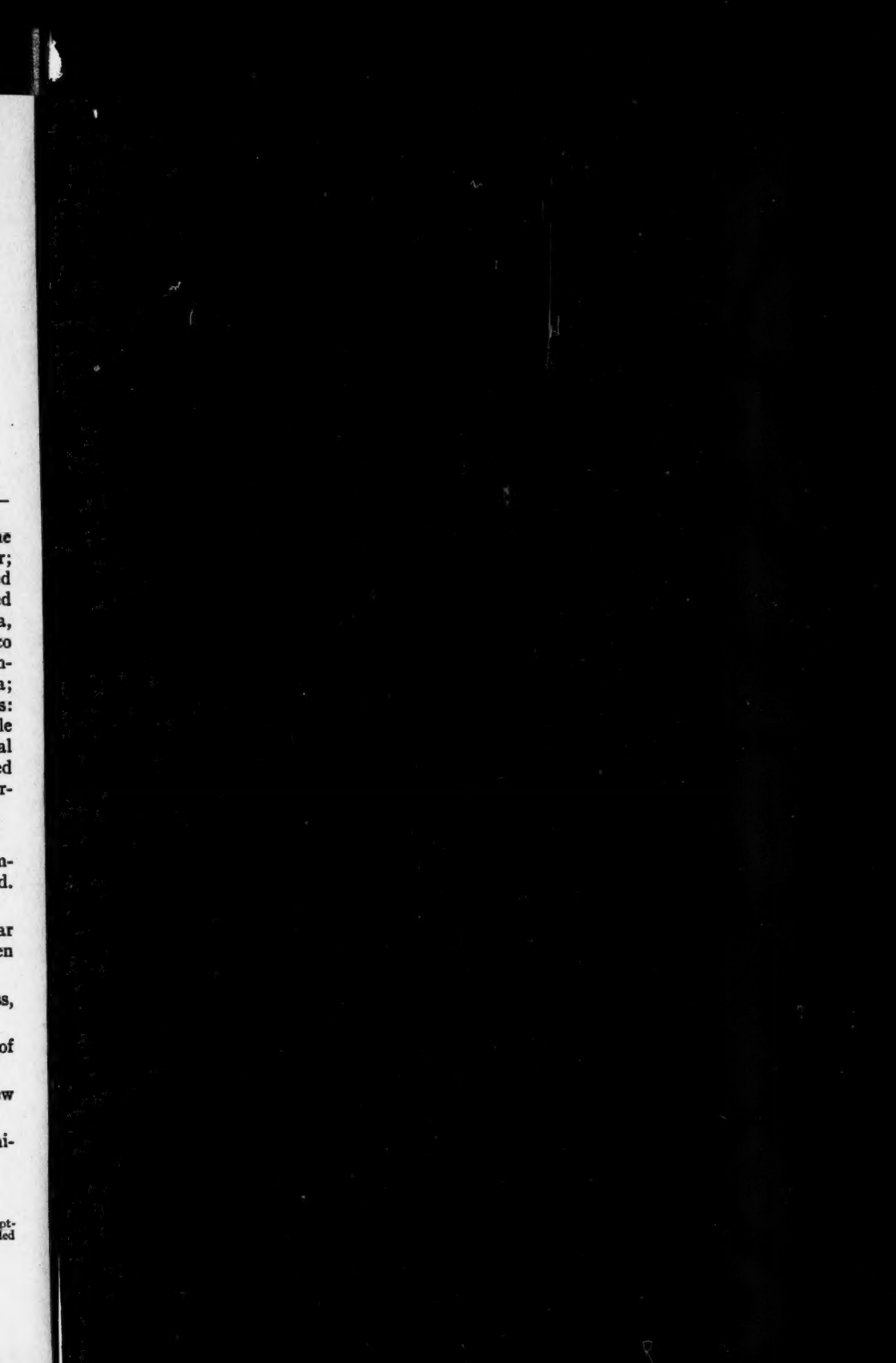
Communications for the editors and manuscripts should be addressed to the Editor of THE SOCIAL SERVICE REVIEW, The University of Chicago, Chicago 37, Ill.

The articles in this journal are indexed in the *International Index to Periodicals*, New York, New York.

Applications for permission to quote from this journal should be addressed to The University of Chicago Press, and will be freely granted.

Entered as second-class matter March 17, 1927, at the post-office at Chicago, Illinois, under the act of March 3, 1879. Acceptance for mailing at special rate of postage provided for in United States Postal Act of October 3, 1917, Section 1103, amended February 28, 1925, authorized March 28, 1927.

[PRINTED IN U.S.A.]



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SOCIAL SERVICE REVIEW

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Edited by
THE FACULTY OF THE SCHOOL OF SOCIAL SERVICE ADMINISTRATION OF THE UNIVERSITY OF CHICAGO

VOLUME XXI
1947

THE UNIVERSITY OF CHICAGO PRESS
CHICAGO, ILLINOIS

THE CAMBRIDGE UNIVERSITY PRESS, LONDON

PUBLISHED MARCH, JUNE, SEPTEMBER, AND
DECEMBER, 1947

COMPOSED AND PRINTED BY THE UNIVERSITY OF CHICAGO PRESS
CHICAGO, ILLINOIS, U.S.A.

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THE SOCIAL SERVICE REVIEW

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A WORLD BILL OF RIGHTS[1]

CHARLES E. MERRIAM

AT THE very beginning one may say: What has a world bill of rights to do with physics and politics—or have you lost the trend? The answer is: Much, perhaps everything; for a world bill of rights provides the essential background or framework for a jural order of the world, without which neither physics nor politics can function. The old-time orders in which physics found a pleasant home or politics found a situs have been upset by revolutionary changes, some of which may be attributed to physics and some of which, equally revolutionary, spring from political relationships.

Without a world bill of rights which is universally recognized and substantially enforced or applied, the future for reflection and peaceful action is very dark indeed. You may ask: Why start with a bill of rights? You might start with a parliament of man; you might start with the organization of a world court or courts, determining what is justiciable, a phrase lawyers like to use; or we might start with functional agencies like health, finance, food, U.N.E.S.C.O., and what not.

When I wrote on an international bill of rights in 1945, the project might have seemed a little nebulous.[2] Some of that still survives here, and you can find a good part of it there. Another part of it is in a volume I wrote farther back than that (1941) in the Godkin Lectures at Harvard under the title of *On the Agenda of Democracy*. There I discussed an economic and a social bill of rights in a broader sense.

The best source of information on this whole subject is, of course, the reports of the Commission on Human Rights under the United Nations, the commission of which Mrs. Eleanor Roosevelt is the chairman.

We may ask: What does the world community really have in common, or what basis is there for a world bill of rights? I proceed on the assumption that there is a common consciousness of rights and wrongs as a basis of humanity, that there are understandings and expectancies on which human conduct in large measure depends. We come back to that later on, but I am only saying that the primary basis is the assumption that you can find in human nature and in human expression of human nature the consensus of judgment which could serve as a

[1] Walgreen Lecture delivered at the University of Chicago, May 20, 1947.

[2] *Annals of the American Academy of Political and Social Science*, January, 1946, a number on "Essential Human Rights," with an article by the present writer on the content of an international bill of rights.

basis for the one world toward which we are coming.

I deal in the first place with the role of declarations of rights. When are rights rights and what is the use of declaring them? I shall deal with the problem of the ethical-legal disputes over rights, with the legal-economic disputes, and with the scientifico-political discussions.

An international bill of rights is a statement of the rights of man in a world setting. There are three sets of new conditions at the root of the present problem. One of these conditions is the development of a jural order of the world, moving in the direction of world government, not so rapidly as many would like, but still moving. Another is the new body of social, economic, and cultural forces in our time. Another is the new discovery and role of human intelligence in human affairs, of which the new research in atomic energy is only a symbol.

Some of the elements of a world bill of rights are already embodied in the structure of the United Nations charter. President Truman says: "The charter is dedicated to the achievement and observance of human rights and fundamental freedoms. Unless we can obtain these objectives for all men and women everywhere —without regard to race, language or religion—we cannot have permanent peace and security" (San Francisco, June 26, 1945).

The new conditions profoundly affect any bill of rights in our day, for they are revolutionary in nature, far more revolutionary than any world revolution that ever has happened or has been imagined by the wildest of revolutionists. The increasing recognition of the dignity of man and the importance of protecting him under new economic and social conditions, the tragic events of World War II, the emergence of the atomic bomb, a mark of the revolutionary triumphs of human intelligence—these factors are a sharp challenge to frame an adequate statement of the rights of man in the twentieth century.

The ends of government remain unchanged in the midst of these alarms. Security, justice, order, welfare, and freedom are universal ends of political behavior, as seen through observation, experience, and reflection. But they are applied under new conditions. The ends have not changed, but the means have changed—under new conditions from time to time as basic changes were made in social, economic, and cultural conditions and in political perspectives.

Obviously, there are many value-systems other than the political—religious values, cultural values, artistic values, social values. A bill of rights will deal with those values that fall in the area of the governmental. The political, it has to be borne in mind, is not limited to the legal; it is not limited to the lawyers or to politics in the formal sense. The political includes a wider range of political ideals and aspirations—things that are not in the law at times. Indeed, a recognition of the pluralism of values is one of the basic conditions of world order, and our present task in framing an international world bill of rights is to place the political values in their proper governmental setting as a part of the general understandings—moral, economic, and cultural—upon which alone world order can be built.

How do these rights come to be rights? From time immemorial the rights of man were derived from the law of nature—*jus naturale*—from Christianity, from human experience, observation, and reflection. They have been a refuge against human might, an altar to which men might flee, a rallying cry for resistance to tyranny or oppression or against arbitrary rule. As time went on, these rights

were brought together in more and more systematic form. They found their way into the Roman law; they found their way into the Stoic philosophy first, I should say. They flowered in the natural law when almost forgotten by governments. They became the basis of revolutionary movements against absolute despotism, the cornerstone of constitutional democracies everywhere, the foundation of twentieth-century political progress.

Again and again it has been contended that these human rights are not true rights and have no place or validity in governmental documents. It has been said that there never was a historical state of nature in which human rights existed prior to the establishment of civil government. It has been said that alleged human rights have no real existence without legal enforcibility. It has been said that these human rights, so-called, possess no special value or political significance.

An eminent justice of the Supreme Court of the United States said: "Of course the Court deals not with Utopias, but with practically enforcible rights." But that is not what the world has ruled in the supreme court of human history. It is held that rights are rights, whether the courts recognize them or not.

Both reflection and experience show that these rights of man have substantial and growing value, for their foundation rests in the nature of human personality and relations. The validity of the claims of human nature is not dependent upon the interpretation or application given by a particular agent or authority at a particular time, important as this may be practically, but upon the validity of the human claim in the framework of advancing civilization with its Jewish-Christian-Roman world background. Rights are an affirmation of the value of the ends of government and an assertion of confidence in the principles upon which all sound political association of human beings rests in the last analysis.

That rights have not been fully recognized or realized does not remove them from the field of the political, for politics deals with ideals as well as with what are called "realities." Ideals themselves are realities of the most real sort. The rights of man provide the domain of faith and hope in government, the court of appeal which is never closed, the law beyond the law and beyond the jurists, the lawmakers, the managers, the adjudicators, and the effectuators. The rights of man go deeper down and higher up than institutional devices for interpreting or applying them, and the vitality of these rights illuminates that recurring poverty of unjust power, which is the hope of freedom in all times.

Have you ever been where might was right? Maybe you have even been held up at the point of a gun when some arbitrary authority, with the words "This is a stick-up," has determined what is right or wrong. Or, on a far more desperate scale, have you ever been where there were no legal or political rights, except the will of someone with a bayonet or gun? Have you ever been where there was no established law of the land, and the administration of the courts and the parliamentarian bodies held that wrong was right, and you were helpless in its face?

One might also say—I want to connect this with the scientific—when Galileo was obliged to recant on the cosmos, you will recall his famous words, which always bear repetition, "E pero se muove"—"nevertheless it moves." Well, "E pero se muove" became the doctrine and has echoed and re-echoed a thousand and a hundred thousand times in camps of concentration, ground by tyranny of the

most brutal, sadistic, and obscene type. If men had not believed that there was right beyond the lash and beyond the bayonet and beyond starvation, where would the world be today!

The most notable statement of human rights is that of the American Declaration of Independence. "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life, liberty and the pursuit of happiness. That to secure these rights [listen to the last part of it] governments are instituted among men, deriving their just powers from the consent of the governed," with the right of revolution as the ultimate appeal—an uncomfortable doctrine for many.

The basic human right, common to all humanity, is the right to live, the right to the fullest and finest development of the potentialities of the human personality in the framework of the common good. This is the root right, from which all others stem. Civil rights, political rights, social rights, economic rights, and scientific rights are implements designed not for themselves but to make more effective the foundation right of them all. This is the right of human personality, with its insistent claim for life-expression and expansion, the recognition of the innate dignity of man, the realization of the possibilities of man and of his unique position in the natural, social, and moral order. Without the understanding of this basic right, the other so-called rights lose their meaning. The attempt to escape the implications of this basic right has led might to divorce itself from right and to stand out in the ugly trappings of force alone. But only as right and might are blended is there genuine authority and genuine justice in human relations.

On this basic right of life is built a long series of guaranties, protections, and safeguards, such as human equality as a prerequisite of a system of justice; respect for the human personality; equality of treatment without regard to race, creed, or sex; freedom of religion; freedom of the press; freedom of association; and a long and changing series of conditions under which life may be enriched.

These may be classified roughly as follows, without insistence on the value of the classification, which is perhaps more historical than logical: (1) civil rights; (2) political rights; (3) economic and social rights; and (4) scientific rights. These are all overlapping rights, all depending on the basic right of life and growth of the human personality. They refer to certain types of situations in which the personality must function if creative development of mankind is the goal. No one of this series of rights is complete without the others. There must be a coordination of social and economic rights with political and civil rights which guarantee and protect them. More than that, no one system alone is adequate without a concert of the family of nations in which it must function.

Civil rights by this time are almost standard in their type. They are now a part of the world idea of human justice. Equality before the law, due process of law, guaranties against arbitrary treatment, civil procedures, and other like protections evolved by long and painful experience are now generally accepted as basic elements in human justice. While their specific provisions and particular methods of application and enforcement may vary from place to place and from time to time or may even be forgotten or ignored or obscured, fundamentals of civil rights are by now universally accepted in theory and should be embodied in an international instrument such as the United Nations charter.

Political rights are by now widely ac-

cepted, but not altogether, as a body of specific measures necessary for the further protection of human personality in its position of dignity and development. They include the right to a system under which the consent of the governed is the accepted basis of all just political authority. They include the right to a system of free elections, freedom of assembly, freedom of speech, freedom of press, freedom of communication and association. They must be incorporated in any international bill of rights in such unmistakable terms as may be adequate and appropriate for the effective guaranty of the right in question.

Economic and social rights are also part of the protections of a world jural order which makes life worth living. They are most difficult in these days, but they make possible the conditions under which the personality of man may be developed and without which civil and political rights may be and have been from time to time rendered utterly meaningless or ineffective. Here are included the right to work, the right to an education, the right to health, the right to housing, the right to social security, the right to recreation, the right to cultural opportunities, the right to a fair share of the advancing gains of civilization. These are just claims upon society for the recognition and protection of personalities, otherwise unprotected and in many cases crushed down below the recognized minimum levels of human living. In our time they are as truly rights as trial by jury or due process of law or the consent of the governed, for they are conditions essential to the full flowering of the personality as truly as are civil and political rights already accepted.

The equal right to sleep under the bridge or to starve or to work for a starvation wage, or the equal right to live in doghouse surroundings—these may be in fact as many other wrongs may be. But this does not make them right in the modern view of the modern world.

It may be, and has been contended at times by various persons, that these new rights have no place in a bill of rights, international or otherwise. When the National Resources Board, of which I was vice-chairman, put out a bill of economic rights, a very distinguished statesman who shall remain nameless here, said: "This is a mixture of moonshine and socialism." Things have changed in four years. But we must use, some say, some other name than that of rights; you must not call these rights—as the right to work. Call them perhaps "conditions," or "goals," or "amiable purposes"—almost anything but rights. Call them amiable purposes to work, I suppose, or amiable purposes to education, or amiable purposes to health, or amiable purposes to get away from doghouse housing, but not rights.

Yet a fuller understanding of the nature of rights and of their historical development indicates that this view is untenable, either from the record or in reason. Historically, bills of rights were not developed in a social vacuum; they grew out of social and economic conditions which imposed intolerable conditions upon men. Bills of rights were bills of wrongs, originally, statements of grievances, of particular ills. Sometimes those who protested looked backward to ancient rights, and sometimes to rights that never were on land or sea, but always men remonstrated and protested in the name of injustice in their own time and place, whether it was taxation without representation or some similar right. They recited claims.

In our own day, likewise, our bills of rights are in part bills of wrongs, protests against intolerable conditions which will not and should not be endured. Fear and

want are symbols of wrongs against mankind which violate the commonly recognized claims of humanity. They are directed against oppression of whatever type or against the indifference of pride and privilege, wherever found, in whatever garb of legality or respectability. Hunger, sickness, unemployment, insecurity, inadequate educational and recreational advantages, unfair shares of production—these are the wrongs of our day, which will not in the long run be denied but remedied in the common judgment of mankind. These conditions are wrongs, and they have their complementary rights. They may be thrown out of court at times because they do not appear in orthodox garb or speak the correct language of precedent, but they will not be deprived of a place in the world declaration of the twentieth-century rights of man.

Many difficulties arise in determining what should be included practically in a world bill of rights. Among the chief difficulties are the contest between the ethical and the legal, between the political and the economic, between the scientific and the political. It would be interesting but, of course, obviously, in the limits of this discussion, impossible to do more than indicate a few of the outstanding questions.

One of these which constantly keeps coming up and which has come up in the United Nations is the relation between the rights of individual personality and the rights of the group or the state. Obviously, individual rights are not valid against all other individual or social claims that may be asserted. On the contrary, individual rights are conditioned by other individuals with other sets of rights, and these rights are reciprocal, but in the jural order of the world they would be conditioned upon social claims which are rationally defensible.

I perused a long discussion in the Commission on Human Rights. Curiously enough, the two chief protagonists were the representatives from Yugoslavia and Lebanon. Lebanon was in favor of the rights of the individual and Yugoslavia was in favor of the rights of the state or the society, and they found great difficulty in getting together. The gentleman from Lebanon found the doctrine of Yugloslavia was totalitarian, and the gentleman from Yugoslavia found the doctrine of Lebanon was out of date, passé, bourgeois. They carried on lusty debate which almost wore out my eyes. What effect it may have had upon their respective throats I do not know. I do not speak disrespectfully of them, for they spoke with great fervor, if not with great effectiveness from my point of view.

Is there an essential controversy between the rights of the individual and the common good? I suppose that all the rights of personality were shaped in a framework of the common good. I have no right to assert myself without regard to others or without regard to the general environment, which you may call "state" or you may call *Gemeinschaft* or whatever the name may be. It would not have been at all impossible, if these gentlemen had not been so excited, it seemed to me, to draw up a formula which would recognize the relationship between the personality and other personalities and the community or association in which they lived. As far as the gentleman from Yugoslavia was concerned, he might well have recalled that in the Marxist theory the state was to wither away altogether as a necessary evil and there would be no state which could make you trouble.

Human personality, apart from the common good, does not exist, nor does the common good exist without regard to the human personalities who make it

up. If you employ a good lawyer or a good political philosopher, you can readily work out an understanding, if you have the will to do so. Of course, if there are only diplomatic sparring and stalling, then you get nowhere, but in the end you can come to a reconciliation.

The question always is, of course: Who decides? Who decides whether my right against a state is effective, or the state's right against me is effective? That is, of course, a process of discussion that has been going on for many years. Within certain limits, the state can decide, but everyone with elementary knowledge of politics knows that there is a point beyond which the state should not go and beyond which it cannot go, which history has shown over and over again tends only to its own destruction. And outside the political association, there are all sorts of other values and other associations—religious, ethical, economic, cultural, racial—values and associations of a score of types.

Another group of rights growing out of the needs of our time centers around the role of intelligence and science in the lives of men. The development of mankind requires that freedom of inquiry and the dissemination of the results of inquiry be protected in order to preserve our civilization. The traditional freedom of speech, freedom of the press, and freedom of religion are not always adequate to meet the new situation in which science plays so startling a role in the affairs of mankind. It is important, therefore, to declare in a bill of rights the fundamental right of man to carry on research and to publish and communicate the findings and conclusions of scientific research. Unless this is declared and implemented, it is possible that the whole growth of scientific research and rational inquiry upon which the future of mankind depends may be slowed down or stopped by the restrictions imposed by various groups, political, economic, cultural, or otherwise. No right is more intimately related to the basic right of life—to expansion and expression of the human personality—than that of the right to think, to full freedom of inquiry and of communication, and to dissemination of the results of inquiry.

For reasons of military security in our day, whether real or fancied, it would be possible to repress and check scientific thought so effectively as to block the development of fundamental science and its application to modern civilization. Thus the military possibilities of atomic energy may be used as a device for keeping secret or suppressing collateral lines of research of tremendous value to mankind.

Without recognition of the right of communication, civil and political rights are ineffective in a jural order of the world. To say that men may study and think but cannot speak is as sounding brass and a tinkling cymbal, void of reality in the development of the basic right of the human personality.

What form would scientific rights take in a world charter of liberties? What is the relation of the scientist to class and nation? In a period of war, of course, active or potential, secrecy of military information, scientific or otherwise, is obviously one of the nation's great assets. In a world of war it is difficult to see how this can be avoided. The result, however, may mean serious crippling of intellectual advance, but in the long run ideas cannot be beaten down by guns. In the meantime, serious delays may be caused in a world rapidly rushing forward to we know not what. All this is an argument for a world order and for universal peace, because if you predicate no world order but only a perpetual war, it is easy to see

how you could influence all kinds of thinking.

Quincy Wright has pointed out in his monumental *Study of War* that differential advantages in technical equipment, real or assumed, have been among the greatest causes of economic warfare. "We have a secret weapon." Nobody knows what these secret weapons are, so I rush in to destroy you and you rush in to destroy me. The group with the new gadget is confident that it can overpower its ancient enemy. That the assumption is contrary to fact may prove disastrous to the aggressor, but it may not stop the war. Witness the submarines, gas, dirigibles, V-bombs, etc.

All this is an argument for the establishment of a jural order of the world in which freedom of scientific inquiry and freedom of communication may go hand in hand with the other freedoms for which men have struggled. The Commission on the Freedom of the Press, of which I was a member, gives a more detailed discussion of international communication in *Peoples Speaking to Peoples*. It demanded the physical freedom of communication—freedom of physical transmission of ideas, lessening of political and economic restrictions, and improving the accuracy and representative character and quality of words and images. I wish I could develop that, but there is no time.

I pass on to the implementation of rights. How to secure enforcement of world rights is a problem of far-reaching importance which it is not possible for me to carry very far. Many methods of compliance have been suggested. One is that the international bill of rights might be enforced by nations, by each of the fifty-odd nations. One is that they be enforced directly by some central court. Of course, the enforcement by a nation might mean that they would not be enforced. Yet enforcement directly upon the citizens of the United States, Russia, and England seems a little beyond what is acceptable at this time, whatever might be the case in the future.

An interesting suggestion has been made by an English writer, Lauterpacht, in his book, *An International Bill of Rights*. Lauterpacht has suggested that we might have, if not an international court with power to deal directly with individuals all over the world, a court that would be called a "Commission of Inquiry." Here, after the rights of man had been declared in an international bill of rights, if Mr. Brown were aggrieved, he might complain to the international commission, or Mr. Jones might complain. The court might then be authorized to make an inquiry or investigation and to make a report, but without the power to punish by fine, imprisonment, or otherwise.

But, you might say, that does not amount to anything. It might not, to be sure, but there are various cases in which publicity has proved to be very important in securing the protection of rights. In the early Massachusetts minimum-wage laws, instead of a law providing for the punishment of an employer, they provided for posting him and for publication in various newspapers. "The YSC Company is paying less than the minimum wage to its employees, contrary to the expressed desire of the Commonwealth of Massachusetts." This in some ways was very effective. There was a period of education. Many employers said: "Well, perhaps we shouldn't be doing this; perhaps we needn't be doing this; perhaps we could make more money without this." And in the long run there came a mandatory statute.

But what good is a declaration if it is

not enforced? That is the old controversy between the lawyers who say, "There can be no right without a remedy," and the students of politics and ethics who say, "There may be rights without a remedy and the declaration of these rights is often of immense importance to individuals and to mankind."

Lincoln's statement of the meaning of the Declaration of Independence at this point has never been surpassed. Said he:

> The declaration was intended to be, and in fact is, a fundamental principle to serve as an ideal for free society, constantly looked to, constantly labored for, and even though never perfectly attained, constantly approximated, and thereby constantly spreading and deepening its influence, and augmenting the happiness and value of life to all people of all colors everywhere. . . . . Not only is it to serve as an ideal toward which men struggle, but it is also to prevent a return to the past—an impressive warning against return to "the hateful paths of despotism."

A world bill of rights may be regarded as a declaration of the interdependence of men and nations. Unless a bill of rights is so conceived and developed, it cannot go far in the elevation of the human spirit. It cannot bring life and light and healing on its wings. It cannot express the high aspirations of mankind in this, the greatest hour of human history, or promote that human unity, understanding, and hope upon which the jural order of the world depends. If we aim at peace, security, prosperity, progress, the growth of the human personality—"life, liberty and the pursuit of happiness" in our own phrase—we must not stutter or stammer over the word "rights" or hesitate to speak out boldly and firmly now. We must use the symbols as well as the law of human hopes and aspirations, not the cautious and elaborate language of anxiety and fear of the unknown.

In the past, great champions of humanity—jurists, statesmen, philosophers, religious leaders, industrial leaders, and others—have helped to find the often devious and zigzag road to human liberties. Meetings in Lake Success in months to come are other challenges to broaden and deepen human rights. We may approach with confidence the new statement of the rights of men that will shed its light down through long stretches of time.

You may say: "You certainly are coming in on a wing and a prayer." Well, I may be coming in on a wing and a prayer. I do not know how good my other wing is or how good my prayer may be. Nevertheless, we are coming in. We have behind us religions which have cast away tribal faiths for one universal religion, however torn by schisms. We have behind us the technology which shrinks time and space and brings face-to-face contact of a universal type. We have behind us the verdict of mankind against the dreadful horrors of another war. We have behind us the spread of trade and commerce, the interchange of goods and services, and the gains that come therefrom on the broadest scale. We have behind us the deeper knowledge of the nature of men and groups of men and the growing recognition of their human likeness and human kind. We have behind us the growing power of science and education moving massively toward the common culture of mankind.

With these powers arrayed in concert, in the effort to obtain the declaration of a common consciousness of rights and wrongs in the ethical and the juristic worlds, we need not despair of a day crowned with success, when faith, intelligence, and will are once fused in action flaming around the world.

UNIVERSITY OF CHICAGO

PAUPER MEDICAL CARE, HEALTH INSURANCE, OR NATIONAL HEALTH SERVICE: THE BRITISH EXPERIMENT

JOHN S. MORGAN

THE National Health Service Act became law in Great Britain last year. It is expected to come into force on July 5, 1948. It was framed by a Socialist government, and in many quarters it has been assumed that any form of national health service is therefore necessarily socialistic. The flurry caused by the British Medical Association and the "Doctor's Poll" has further obscured the real issues by making it appear that the medical profession in Great Britain is wholly opposed to any publicly operated national health scheme. The fact of the matter is that the National Health Service Act is the inevitable consequence of a historical process. It is the product of experience with other forms of medical care which have failed to achieve the main objective. That aim is the preservation of a healthy population, the prevention of ill-health, and the speedy cure of sickness, not only in the interests of a healthy nation, but also in order to create an efficient people whose productive capacities are not impaired by the economic and social wastefulness of ill-health.

Some kind of medical care has for long been among the services available to the destitute. The monastic institutions had their great infirmaries for the care of the sick. The Elizabethan Poor Law contained provision "for the necessary relief of the lame, impotent, old, blind and such other among them being poor and not able to work."[1] The Webbs noted that the Royal Commission on the Poor Law of 1834 made no reference to the needs of the sick and that, in consequence, the provision of domiciliary medical treatment by the boards of guardians which had become established by 1907 was inadequate and inefficient.

"Lavish and indiscriminate grant of Medical Orders, by medically unqualified persons, without any verification .... has, we think, a disastrous effect, both on the quality of the service rendered and the spirit in which it is accepted."[2] Moreover, they point out that there was a natural reluctance to seek medical aid from the 3,713 district medical officers because such aid was associated with destitution, and that this unwillingness to seek necessary medical attention had a grave effect on the public health.

On the other hand, the rapid development of the Poor Law infirmaries where the sick poor were given hospital treatment meant that the destitute were getting hospital care which was not available to the poor who were not destitute. In addition, there was some provision of medical and hospital care (described by the Webbs as being in 1906 "merely a skeleton service") by the municipal authorities under the Public Health Acts. To add to the confusion there were other agencies trying their desperate best to meet the obvious needs of the sick and suffering. Among them, notably, were the Free Dispensaries (or

[1] 43 Elizabeth, c. 2 (1601).

[2] Sidney and Beatrice Webb, *The Break-up of the Poor Law* (London, 1909), chap. v.

medical missions), the out-patient departments of the great voluntary hospitals, the various forms of "contract medical practice" operated by local clubs and Friendly Societies, and the Medical Provident Associations started by groups of doctors or by philanthropic committees. This latter was an inadequate form of what is now called prepayment medical care and, like most of its modern successors, was unrelated to preventive medicine or to public health or to health education, being too often the "dispensing of physic rather than the care of health."

Amid this confusion the Webbs called for a state medical service as the basis of a sound public health policy, "searching out disease, securing the earliest possible diagnosis, taking hold of incipient cases, removing injurious conditions, applying specialised treatment, enforcing healthy surroundings and personal hygiene, and aiming always at preventing either the recurrence or spread of disease."[3]

In spite of the clear need to tidy up the situation, this confusion remained, and the Poor Law medical services and the Poor Law hospitals were still part of the social services of Great Britain when World War II broke out. If anything, the confusion was made worse by the attempts which were made to remedy it. The inauguration of National Health Insurance set up another system of medical care largely unrelated to those which already existed. The development of school medical services,[4] maternity and child welfare services,[5] and tuberculosis and other categorized services certainly took the responsibility for the care of some of the sick from under Poor Law administration but added new complexities to the crazy structure of medical care. The Local Government Act of 1929, by giving permissive powers to health committees of local authorities to take over Poor Law hospitals and organize a public hospital service, appeared to be a step in the right direction, but, as many authorities failed to use their powers, it merely added one more agency for health to those already in the field. The Local Government Act of 1929, however, although its powers in this matter were not used by many local authorities, did signify at last the public acknowledgment that sickness is not a matter of destitution and that its prevention and cure is a matter for a health authority and not a destitution authority.

Meanwhile Britain had embarked on a great experiment in the National Health Insurance program[6] which it was hoped would be the bulwark of the nation's health. Although it brought, finally, 17,620,000 persons within reach of medical care and expended more than £27,000,000 (in 1945),[7] it has been found wanting and is to be replaced.

This program covered only the industrial employees in the lower-income groups, while their dependents had to seek care where they could find it. The self-employed, too, were left to their own devices. One good illustration of how this limited coverage affected the whole picture of the social services can be seen in the fact that it has been estimated that there were in 1939 approximately 900,000 persons who were covered against the economic consequences of industrial injury or disease under the workmen's

[3] *Ibid.*

[4] First started under powers contained in the Education (Administrative Provisions) Act of 1907.

[5] Beginning with the Maternity and Child Welfare Act of 1918.

[6] National Insurance Act, 1911 ff.

[7] *Report of the Chief Medical Officer of Health for England and Wales, 1946.*

compensation acts and who were not compulsorily insured under the national health insurance acts and therefore, in the majority of cases, were ineligible for the medical services which they might be presumed to need.[8]

National Health Insurance provided only limited benefits in the shape of medical care. The provision in the National Health Insurance Act is very vague. It calls only for "adequate medical treatment and attendance from the medical practitioners with whom arrangements are so made."[9] This phrase was generally interpreted to mean that the services to be expected were those available from an ordinary general practitioner. In addition to this statutory medical benefit there were "additional benefits" which might be available if the Approved Society to which the insured person belonged had sufficient surplus funds to provide them. These "additional benefits" covered a variety of needs, the most important of which were dental care, ophthalmic care, convalescent home care, and medical and surgical appliances, which were in 1939 available in varying combinations to about ten and a half million out of the seventeen and a half million insured persons. Of the other additional benefits, hospital care covered about one and a half million, care in approved charitable institutions about seven and a half million. The remaining benefits were only available in rapidly descending order of coverage.[10] The weaknesses in medical provision have been succinctly summarized by Sir Arthur Newsholme:

> Apart from the restricted and unequal extensions of medical benefit provided by those Approved Societies which possess available surplus funds—and not completely supplied even by those exceptional societies—medical benefits under National Health Insurance are incomplete in certain respects:
>
> 1. There is no provision for treatment in hospital or alternative treatment at home for serious operations or other conditions requiring expert medical service.
>
> 2. Apart from limited consultations possible with regional medical officers, who may be described as generalized specialists, there is no provision under the Act for consultation as to diagnosis for obscure causes of disease, or for treatment of the eye, ear, throat, gynaecological or other cases needing special diagnosis and treatment.
>
> 3. There is no provision for pathological and physical aids (x-ray examinations, etc.) in the diagnosis of disease and guidance as to its treatment (in 1914 national funds had been set aside for providing facilities for insured and non-insured alike, apart from insurance organizations but the War [1914–18] intervened. At the same time funds were allotted for providing specialist help for insured persons, but this fell through, on account of the War).
>
> 4. There is usually no provision for nursing the sick. Insured persons, like others of limited means outside the insurance scheme, depend on voluntary and official hospitals, and on the Queen's Nurses and the County Nurses' Associations.[11]

Clearly the National Health Insurance schemes were quite inadequate to the real need.

Of the administration of the scheme, it can be said without question that it was unsatisfactory. It was carried on, through a complex arrangement, by the Approved Societies, who were the lineal successors of the old Friendly Societies.

"Historians and others have apparently overlooked the fact that the working classes were driven to mutual help by insurance not because it appeared to

[8] Hermann Levy, *National Health Insurance* (London: Cambridge University Press, 1944).

[9] National Health Insurance Act, 1936, § 35 (2) (repeated from the Act of 1911).

[10] Levy, *op. cit.*, pp. 96 ff.

[11] Sir Arthur Newsholme, *International Studies on the Relation between the Private and the Official Practice of Medicine*, III (1931), 42. (Quoted in Levy, *op. cit.*, p. 30.)

them the most dignified way of securing medical help and funeral benefit but because there was no other way of avoiding pauperization"[12] is the condemnation made by one important student of the Friendly Societies, about which the social historians have hitherto been unduly uncritical.

Beveridge, summing up the arguments for and against the retention of the Approved Societies, wrote:

> Without belittling in any way the services rendered by all kinds of societies in the launching of health insurance, it is possible to decide that the time has come to make health insurance national. The reasons leading to this conclusion may be summed up under two heads: first, that the approved society system is inconsistent with the policy of the national minimum; second, that the approved society system has disadvantages for the insured persons and involves unnecessary administrative costs, while the compensating advantages which it may provide for such persons can be obtained in other ways.[13]

Beveridge was among the milder critics of the Approved Societies and sought to retain them, but in a drastically altered form.

The National Health Insurance scheme, however, had two fundamental weaknesses. First, it was primarily an insurance scheme to afford some protection against the economic consequences of ill health. The whole machinery of administration, from the insurance branch of the Ministry of Health to the smallest unit of the Approved Societies, was concerned not with health but with money. It was on "sick-pay," on the costs of medical care, and on the actuarial complexities of the scheme that the local insurance committees and the civil servants spent their time. Beveridge himself made this clear when he argued that want is a state which requires economic aid, whatever the cause, while health should be primarily the responsibility of a comprehensive health service.

The second fundamental weakness was that of any insurance scheme, namely, that it subordinated sickness to actuarial calculation. "If public medical care is made to depend upon insurance status, the criterion of medical need—the only relevant test—yields first place to criteria which are medically irrelevant—insurability or stamps on a card."[14]

If the medical care available to the British citizen was limited, the hospital and specialist provision was chaotic. The position at the outbreak of World War II is summed up in Appendix A of the White Paper[15] prepared by the Coalition Government in 1944. Except for inspection and registration of nursing homes, there was no supervision or control of private fee-paid provision. The voluntary hospital system provided some 77,000 hospital beds which were available in everything from a great teaching hospital to a small cottage hospital which had no adequate equipment for more than the simplest hospital care. It is significant that there were only 75 of these voluntary hospitals with more than 250 beds, while over 500 of them had less than 100, and 150 of them had less than 25 beds available for general hospital duty.

The public hospital service fell into two parts: the Poor Law hospitals and the hospitals provided by the public health authorities. Although the Local Government Act of 1929 authorized the

[12] Hermann Levy, "The Economic History of Sickness and Medical Benefit since the Puritan Revolution," *Economic History Review*, Vol. XIV, No. 2 (1944).

[13] Sir William Beveridge, *Social Insurance and Allied Services: Report* (Cmd. 6404, 1942), sec. 60.

[14] *Medical Care for Citizens* (P.E.P. Pamphlet 1944), p. 2.

[15] *A National Health Service* (Cmd. 6502, 1944).

transfer of the Poor Law Hospital to the Health Authority and the establishment of a public hospital service, only a limited number of local authorities had in fact made the change. The public hospitals provided in 1939 something like 130,000 beds, about 60,000 being in Poor Law hospitals.

There was no co-ordination between the hospitals, no spread of the burden, so that one hospital might stand half empty, while another near by might have an overlong waiting list of patients. Specialist and consultant services were concentrated in the large towns and especially in London. Still less was there any systematic co-operation between the hospital service and the medical care services.

The whole health situation was well known. Official committees, like the Voluntary Hospitals Committee, 1921 (chairman, Lord Cave), and the Committee on the Scottish Health Services, 1936 (the "Cathcart Report"), had reported to the government.[16] Of the unofficial and semiofficial inquiries, perhaps the most important were the ones conducted by Political and Economic Planning and the British Medical Association. The P.E.P. report, which explores the whole situation in considerable detail, opens with the classic comment: "The mere fact that no comprehensive approach to the health services was available, and that it has taken a group of ordinarily intelligent people three years to hammer out this preliminary synthesis, is conclusive proof that the subject was in a serious state of confusion."[17]

The medical profession was quite as critical as anyone else of the nation's health services. As damning a summary of the criticisms of the available services as can be found anywhere was issued in 1942 by the British Medical Association:

> The foregoing criticisms may be summed up in the general criticism that there has been no comprehensive national health policy to guide legislative and other developments in the sphere of medical service. The distribution of executive and administrative functions among statutory bodies, both central and local, has been haphazard. There are too many central and local bodies concerned with one or another aspect of the country's health services and too little collaboration between statutory bodies and between statutory and local bodies. There has been insufficient consultation with the medical profession both centrally and locally on those important aspects of health administration upon which it is well fitted to advise. . . . .
>
> . . . . The benefits of National Health Insurance are restricted to wage-earners, though the needs of dependants of insured persons and other persons of similar economic status are no less. The benefits of this scheme are also severely limited in that they do not include as statutory benefits consultant, specialist and institutional services. Another complaint is that economic status rather than medical need is felt to be too often the criterion of eligibility for medical service. The distribution of doctors, both general practitioners and specialists, is said to be governed more by the economics of the medical profession than by the medical needs of the various types of area. . . . .
>
> . . . . Many of the differences that exist between the two systems [the statutory and voluntary hospitals] such as the conditions of admission of patients and the opportunities offered for professional careers, are fundamental and their continued existence is detrimental to the development of an efficient hospital service.[18]

These are only some of the trenchant criticisms offered by the profession, with the only qualification that "while it is not necessary to accept them all as of equal importance or validity, it cannot be denied that there is some foundation for most of them."

The B.M.A. in its first statement in

[16] *Ibid.*, Appen. B. A note of the major inquiries on the health and hospital services is given here.

[17] *Report on the British Health Services* (P.E.P. Pamphlet, 1937), p. 2.

[18] Medical Planning Commission, *Draft Interim Report* (British Medical Association, 1942), pp. 5–11.

1938[19] and in its *Draft Interim Report* in 1942[20] was, however, less concerned to criticize the situation than to propound solutions. These studies, and many others like them, all had certain common features. In fact, when all the partisan arguments are discarded, there was, by 1942, a remarkable unanimity throughout all the various discussions on the major necessities of a health plan. Briefly, all were agreed that every individual should have access to the medical services he needs; there should be an integrated service of medical care in which the medical practitioner, the public health authority, the hospital service, and the consultant services were related parts of a not-too-complicated service; and, finally, it would be necessary, especially in developing the hospital service, to organize some part of the health service in much larger administrative areas than were available through the existing system of local government.

The experiences of World War II really clinched the arguments. Urgent necessity compelled the creation of a unified health service which was primarily aimed at the health of the patient rather than the maintenance of existing institutions or the protection of vested interests. The establishment of adequate laboratory services, through the Emergency Public Health Laboratory Service, and the development of essential laboratory services in the hospitals filled one of the great gaps in medical and hospital provision. The development of a unified Blood Transfusion Service and of food and nutrition policies as part of the nation's total policy of achieving and maintaining maximum health in the nation; the great advances in health education; and the establishment of rehabilitation programs were only a few of the marked advances in Britain's health services.[21]

Without question, however, the major lesson was to be found in the establishment of the Emergency Medical Service (E.M.S.), which mobilized all the medical men and resources and used them where they were needed, and the E.M.S. hospital scheme, which brought all the hospitals within a single administrative pattern, national in scale and administered on a regional basis. Within this integrated scheme over three thousand hospital units were available, of which over one thousand were "upgraded" to Class I hospitals by the provision of adequate laboratory and hospital equipment and by the allocation of adequate specialists and medical services. All accommodation was pooled; patients could be transferred to where there was bed space or available special care; consultants were dispersed throughout the whole country and attached to the hospitals and the universities; mobility of medical staffs was increased by the establishment of salaried staffs and fee-paid consultants. Many areas of Great Britain found themselves for the first time within the reach of hospital care of the finest modern standards.

In a word, a national health service was established and it worked. With the full support and co-operation of the medical profession, a government department had ironed out the techniques of administration which left management with the local units, co-ordination and regulation with the regional officers of the Ministry of Health, and the control and

[19] *A General Medical Service for the Nation* (British Medical Association, 1938).

[20] *Op. cit.*

[21] The full details can be studied in the *Report of the Chief Medical Officer of the Ministry of Health on the State of the Public Health during Six Years of War* (H.M. Stationery Office, 1946).

guidance of the whole plan with the central government. That a state medical service could achieve full service for the patient had long been suspected, for in the Highlands and Islands Medical Scheme, established in 1912, the Department of Health for Scotland had been operating a scheme which brought modern medicine to the crofters of the barren highlands of Scotland. Now it was clearly shown that a state-guided scheme could serve the whole nation and give it, even in wartime, a better health service than it had ever had.

In the light of the story which has been sketched here, it is not surprising that the White Paper, *A National Health Service*, proposed a complete reorganization of the nation's health services. It is significant that, as its basic principles, the government now accepted three main objectives:

1. To ensure that everybody in the country—irrespective of means, age, sex or occupation—shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available.

2. To provide, therefore, for all who want it, a comprehensive service, covering every branch of medical and allied activity, from the care of minor ailments to major medicine and surgery; to include the care of mental as well as physical health, and all specialist services, e.g., for tuberculosis, cancer, infectious diseases, maternity, fracture and orthopaedic treatment, and others; to include all normal general services, e.g., the family doctor, midwife and nurse, the care of the teeth and of the eyes; the day-to-day care of the child; and to include all necessary drugs and medicines and a wide range of appliances.

3. To divorce the care of health from questions of personal means or other factors irrelevant to it; to provide the service free of charge (apart from certain possible charges in respect of appliances) and to encourage a new attitude to health—the easier obtaining of advice early, the promotion of good health rather than treatment only of bad.[22]

[22] *Op. cit.*, p. 47.

This, it must be emphasized, was the declaration of a Coalition Government and was laid before Parliament by a Conservative Minister of Health.

It is interesting to compare with this forthright statement the more cautious aims of the medical profession, drafted originally in 1938[23] and largely confirmed in 1942:[24]

I. That the system of medical service should be directed to the achievement of positive health and the prevention of disease no less than the relief of sickness.

II. That there should be provided for every individual the services of a general practitioner or family doctor of his own choice.

III. That consultants, and specialists, laboratory services, and all necessary auxiliary services, together with institutional provision when required, should be available for the individual patient, normally through the agency of the family doctor.

IV. That the several parts of the complete medical service should be closely co-ordinated and developed by the application of a planned national health policy.

The National Health Service Act of 1946 is, then, really the legislative outcome of the best thinking of the day by all parties. In its final shape it is, inevitably, molded by the prevailing political climate, but, in its essential purposes and in most of its proposals, it follows the lines laid down by the discussions of the last thirty years and shaped by the lessons of war.

The economic consequences of illness are excluded from the health service. Sick benefit is included among the forms of protection from economic want in the contributory scheme for the whole nation embodied in the National Insurance

[23] *A General Medical Service for the Nation* (British Medical Association, 1938), p. 8.

[24] Medical Planning Commission (British Medical Association, 1942).

acts[25] and administered by the Minister of National Insurance. Health services are thus finally severed from destitution. It will no longer be necessary to be poor to get health treatment.

The responsibility for the health services is placed firmly where it belongs, on the Minister of the Crown responsible, with his colleagues in the Cabinet, to the elected representative of the people. In this connection it is relevant to recall the views expressed by the Coalition Government:

> Central responsibility must rest with a Minister of the Crown, answerable directly to Parliament, and through Parliament to the people. The suggestion has been made that, while this principle should be accepted, there is a case for replacing the normal departmental machinery by some specially constituted corporation or similar body (perhaps largely made up of members of the medical profession) which would, under the general auspices of the Minister, direct and supervise the service. . . . .[26]

While recognizing the need for devices which would give full weight to the technical and professional advice of the medical profession, the White Paper repeats the firm declaration of public responsibility which is the essence of democracy.

The National Health Service Act of 1946 sets up a Central Health Service Council of forty-two members, of whom twenty-two must be members of the medical profession (distributed over the various types of practice according to a schedule), which has the right to consider any matter affecting the service and report to the Minister. Its annual report must, with a very limited power of exception "in the public interest," be transmitted to Parliament. Full rights of criticism are thus preserved for the medical profession.

The whole hospital services are brought into a single integrated hospital service, organized as the medical profession has long wished it to be organized, in large regions, integrated with consultant services, and based on the universities, from which the service can hope to benefit by specialist service, research, teaching, and the contribution of university technicians in the allied sciences, such as biology, psychology, or pathology. Administration of the service, on the pattern learned in the war, is to be handled regionally, under the general guidance of the Minister, through a Regional Hospitals Board, on which the profession is to be fully represented. The teaching hospitals are exempted from the general scheme and, instead, are to co-operate more closely with the universities with which, for teaching purposes, they must necessarily be very nearly allied. This reorganization involves the transfer of the voluntary hospitals from their present control and of the public hospitals from the local authorities to the Minister. This transfer has caused much heartburning, but it is difficult, faced on the one hand with the chaos before 1939, and on the other with the undoubted success of the E.M.S. Hospital Scheme during the war, to evade the clear evidence that it is the only effective way to achieve any adequate hospital service. The hospitals themselves will be operated by hospital management committees.

The general medical, dental, and pharmaceutical services are to be organized by local executive councils on which at least twelve out of twenty-five members will be representatives of the professions, and in all probability some of the remainder will also be practitioners.

[25] The National Insurance Act, 1946, and the National Insurance (Industrial Injuries) Act, 1946.

[26] *A National Health Service* (H.M. Stationery Office, Cmd. 6502, 1944), pp. 12 ff.

Every medical practitioner now in practice has the right to come into the service, and every citizen has the right to choose the doctor within the service from whom he wishes to receive general medical attention. Thus the "free choice of doctors," about which there has been so much public controversy, is specifically written into statute law.[27] The control of the establishment of new practices and the encouragement of new doctors to establish themselves in the "underdoctored" areas are to be in the hands of a Medical Practices Committee, of which the chairman and at least six out of the total of nine must be medical practitioners, and, of those six, at least five must be engaged in active practice. The doctors are thus well protected against nonprofessional judgments in professional matters.

The local authorities are to continue to provide the auxiliary services of good health, such as maternity and child welfare clinics, domiciliary midwifery, health visiting, home nursing, vaccination and immunization services, and ambulance service. They are also empowered to establish health centers[28] where doctors, dentists, and pharmacists in the new service will be able to practice with all the essential equipment of modern diagnosis and treatment and also get necessary clerical and laboratory assistance to relieve them for their proper tasks of medical care.

It is sometimes said in criticism of the new scheme that it is primarily a medical-care scheme rather than a health scheme.[29] It should not be forgotten that there are other public provisions which are closely related to, though not part of, the new Health Service. Public health education, indeed, is included in the responsibilities of the Minister and of other agencies in the scheme. The environmental services of public health, of housing, of education; the development of a sound national nutrition policy under the Ministry of Food; the expansion of welfare services in industry under the guidance of the Ministry of Labour and National Service—all these have their place in the armory of a total health program. To this more positive approach also belong the great strides which are now being made in the rehabilitation and re-employment of disabled persons[30] under the direction of the Ministry of Labour and National Service.

A more valid criticism would seem to be the failure to incorporate more substantial provisions, in the National Health Scheme itself and in many of these auxiliary services, for the use of social workers. The hospital almoners have been accepted as essential partners in hospital service, and the psychiatric social workers in mental health services and child guidance clinics. There is just as much need for medical social workers in the health centers, in the clinics, and as allies of the medical practitioners. Already the need for social rehabilitation is being recognized as an important stage in the rehabilitation services, which now provide medical, physical, and vocational rehabilitation.

The cost of ill-health is incalculable.

[27] National Health Service Act 1946, sec. 33 (2) (b).

[28] See *Draft Interim Report of the Medical Planning Commission* and § 21 of the National Health Service Act, 1946, pp. 25 ff.

[29] Cf. the criticism of the White paper on *Medical Care for Citizens*, p. 1.

[30] See (i) *Report of the Interdepartmental Committee on the Rehabilitation and Resettlement of Disabled Persons* (H.M. Stationery Office, Cmd. 6415, 1943).

(ii) The Disabled Persons (Employment) Act, 1944.

(iii) *Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons* (H.M. Stationery Office, 1946).

Pain and suffering to the individual cannot be measured in cash. The strains upon the individual's family; the cost to the community; the loss of productive capacity and its charge upon industry—all these are the hidden costs of sickness. It was calculated in 1937 that on a conservative basis the direct costs of ill-health were £185,000,000 a year[31] or one twenty-fifth of the national income. Against this figure the net additional expenditure of £95,000,000 a year[32] which the National Health Service is estimated to cost seems a modest expenditure for a comprehensive service which will be free to the patient in need of care.

Beveridge said of his plan for income security and its relevance to America:

> Though you have many of the same problems of social insecurity, it does not follow in the least that you ought to deal with them by the same methods as we adopt here. Social insurance, above all, should be national. What another country does may be very interesting to other countries, may be worth knowing about, but it is certainly not a thing to copy slavishly. The social security plans of each people are part of its national culture, and should be adapted to its national tastes, like its houses, or its education, or the shapes of its women's hats, or the meaning which it attaches to the word "cracker."[33]

The same might well be said of Britain's National Health Service, and yet there seems an unhappy tendency to wipe it off the slate as "more Socialism" and to ignore the fact that it embodies in large measure the thinking of all the political parties, the students of social affairs, and the medical profession in Britain over the last thirty-five years. In the light of Britain's experience, the Taft Bill (S. 545) now before Congress seems strangely akin to pauper medical care. The new version of the Wagner-Murray-Dingell Bill (S. 1320) appears to be an opening for the establishment of forty-eight or fifty-two medical insurance plans which would certainly create the kind of confusion from which Britain has for so long been trying to escape.

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[31] *Report on the British Health Services* (P.E.P. Pamphlet, 1937), pp. 387 ff.

[32] The financial memorandum to the National Health Service Bill (H. of C., 1946).

[33] "On Going to America," *The Pillars of Security* (1942), p. 177.

THE INHERENT PROBLEMS IN PLANNING A NATIONAL HEALTH SERVICE[1]

JOHN G. HILL

THE objective of the British National Health Service Act passed by the Labour Government in November, 1946, to provide comprehensive medical services free of charge to every person in England and Wales[2] irrespective of income or social-insurance status or any other qualification had been widely and vigorously advocated by all the more important sections of the British population. The growing realization, accelerated by the war, of the preventable toll of human life and suffering and the loss of manpower and other resources due to illness and physical disability and the overlapping, uneven distribution and gaps in the nation's health services had aroused a resolute demand by a considerable majority of the electorate for all-inclusive health services equally available to all. A program for the prevention and treatment of disease and disability in order to maintain capacity for work had been one of the three basic assumptions underlying the comprehensive social security recommendations to eliminate want set forth in the Beveridge *Report*. The proposals of the Coalition Government in its White Paper of 1944 on a national health service had had the same fundamental aims and purposes.[3]

Even the medical profession, the traditional opponent of socialized medicine, had for years in Great Britain been advocating extension of the services and more complete coverage under the compulsory National Health Insurance scheme, which had been in operation for almost thirty-five years. In a statement issued the day following release of the Coalition Government's White Paper on the proposed new health scheme, the British Medical Association said:

> With the Government's objects, to make available to everybody in the country who needs it, irrespective of age, sex or occupation, an equal opportunity to take advantage of a comprehensive health service, the medical

[1] The writer wishes to express his sincere appreciation to Dr. Eveline M. Burns, of the New York School of Social Work, for her many helpful suggestions in the preparation of this article.

[2] A separate bill containing similar provisions for Scotland was introduced into Parliament on November 6, 1946, the day the National Health Service Act received royal assent. The differences between the two measures are largely administrative, considered necessary because of differences in geography and local governmental structure.

[3] The Coalition Government White Paper of 1944, *A National Health Service* (Cmd. 6502), and *A National Health Service: The White Paper Proposals in Brief* (both issued by the Ministry of Health and the Department of Health for Scotland), stated:

"The new service is designed to provide, for everyone who wishes to use it, a full range of health care. No one will be compelled to use it. Those who prefer to make their own arrangements for medical attention must be free to do so. But to all who use the service it must offer, as and when required, the care of a family doctor, the skill of a consultant, laboratory services, treatment in hospital, the advice and treatment available in specialized clinics .... midwifery, home nursing and all other services essential to health. Moreover, all these branches of medical care must be so planned and related to one another that everyone who uses the new service is assured of ready access to whichever of its branches he or she needs..... The new health service in all its branches will be free to all, apart from possible charges where certain appliances are provided."

profession is in the fullest sympathy. It will play its full part in achieving this object.[4]

This prevailing agreement on the end to be achieved cleared the air, during discussion of the legislation, for consideration and analysis of the means to be employed. A number of complex difficulties emerged. Some of these problems presented obvious, even though occasionally formidable, solutions. Assuming an electorate able and willing to appropriate sufficient funds, the construction of adequate hospital facilities in all parts of the country, for example, becomes largely a matter of time. Where present shortages preclude immediate availability of some services to everybody, priorities were usually determined and accepted with little or no difficulty. Thus, because of the extreme shortage of dentists in England, dental care under the new program will be limited, at first, to expectant and nursing mothers and young children, with adolescents to be added later. The stubborn fact that a full national health service cannot be built in a day admits little argument.

Other problems associated with the new service, however, were what can be described as inherent and vastly more perplexing; they allowed no clear-cut solutions, and, for the most part, sufficient experience was lacking to indicate the most practicable course. What, for example, was to be the method of distributing the doctors in relation to the need for general medical services throughout the country, including the most unattractive areas? What was to be the rate, and especially the method, of remunerating the doctors: flat salary, fee-for-service, capitation fee? What proportion of representation on administrative bodies and what degree of final authority should be accorded the medical profession? How, under the immediate pressing need for hospital accommodation, were the voluntary (private, nonprofit) hospitals to be co-ordinated with the public hospitals in such a way that each region would be assured an equitable share and an even standard of available service? What degree and manner of central control and local administration would best achieve, at one and the same time, over-all co-ordination and efficiency and maximum local participation and enterprise? The sharp differences of opinion, especially between the views of the medical profession and the proposals of the government, in answer to these and similarly irksome questions give the public debates and discussions concerning the British National Health Service Act singular interest and broad significance.

[4] Mimeographed release of the British Medical Association, dated February 18, 1944.

PRINCIPLES INDORSED BY THE MEDICAL PROFESSION

Before publication of the National Health Service Act in bill form, the Negotiating Committee of the medical profession,[5] organized for the purpose of presenting to the government the views of the profession on the new service, formulated and made public a set of principles indorsed by the medical profession as a whole, in which "were expressed in general terms the basic tenets of the profession on the subject of the organization of the country's medical services." These principles were as follows:

[5] The Negotiating Committee of the medical profession is composed of representatives of the British Medical Association, the Royal College of Physicians of London, the Royal College of Surgeons of England, the Royal College of Obstetricians and Gynecologists, the Royal Scottish Medical Corporations, the Society of Medical Officers of Health, the Medical Women's Federation, the Association of Nonteaching Voluntary Hospitals, and the Society of Apothecaries.

I. The medical profession is, in the public interest, opposed to any form of service which leads directly or indirectly to the profession as a whole becoming full-time salaried servants of the State or local authorities.

II. The medical profession should remain free to exercise the art and science of medicine according to its traditions, standards, and knowledge, the individual doctor retaining full responsibility for the care of the patient, freedom of judgment, action, speech and publication, without interference in his professional work.

III. The citizen should be free to choose or change his or her family doctor, to choose, in consultation with his family doctor, the hospital at which he should be treated, and free to decide whether he avails himself of the public service or obtains the medical service he needs independently.

IV. Doctors should, like other workers, be free to choose the form, place, and type of work they prefer without governmental or other direction.

V. Every registered medical practitioner should be entitled as a right to participate in the public service.

VI. The hospital service should be planned over natural hospital areas centered on universities in order that these centers of education and research may influence the whole service.

VII. There should be an adequate representation of the medical profession on all administrative bodies associated with the new service in order that doctors may make their contribution to the efficiency of the service.

The second, third, and possibly the fifth of these principles appear to have occasioned little difficulty in themselves. All political parties have agreed to the principle of the professional freedom of the doctor in caring for a patient, and it has not generally been contended that this principle has been *directly* infringed either in the act itself or in the proposed regulations to be issued under it by the Minister of Health.[6] What disagreements have arisen in this respect are concerned with what will or will not lead indirectly to such professional interference, but these differences are, for the most part, more closely related to other principles of the Negotiating Committee.

Similarly, charges of direct encroachment on the freedom of the patient in selecting or changing his doctor have been few. The act provides for local executive councils[7] to contract with general medical practitioners (as well as ophthalmologists, opticians, and pharmacists) for their services in the new program. Each executive council will then publish lists of its member-practitioners, from which persons in the area who wish to avail themselves of the public service will have the right to choose the doctor by whom they wish to be attended, subject to the consent of the practitioner chosen and to a limit that may be prescribed on the number of patients that may be cared for by any one doctor. The relationship of the doctor with any person on his list will then be the same as the ordinary doctor-patient relationship, with the exception that the remuneration of the doctor will not be paid by the patient but will come from public funds. Patients will have the right to change their doctors for any reason. A panel patient, at his own expense, will also be free to obtain the services of a doctor on a private basis, provided that the patient is not on the doctor's list as a public patient or on the list of a doctor in partnership with him.

There has also been relatively little discussion with respect to the principle

[6] The January 18, 1947, issue of the *Lancet*, an authoritative British medical journal founded almost one hundred and twenty-five years ago, stated, in an editorial appraisal of the new service in relation to the principles of the Negotiating Committee, that, in its opinion, this principle has not been violated.

[7] The constitution and manner of appointment of executive councils will be described later in connection with the Negotiating Committee's fourth principle (see below, p. 463).

that every registered medical practitioner should be entitled as a matter of right to participate in the new service.[8] Such professional opposition as might conceivably be based on this principle is concerned with the controls that will be employed to assure an even geographic distribution of general practitioners, whereby a doctor will not be allowed to enter the public service in an area where the number of general practitioners is already considered adequate. This problem, however, is more directly related to the fourth principle, which will be discussed later.

METHOD AND RATE OF REMUNERATING THE DOCTORS

One of the thorniest problems in the government's negotiations with the medical profession has been the method and rate of remuneration of the doctors, which is the subject of the Negotiating Committee's first principle: *The medical profession is, in the public interest, opposed to any form of service which leads directly or indirectly to the profession as a whole becoming full-salaried servants of the State or local authorities.* In anticipation of these difficulties, this aspect of the new program was not dealt with in the act but was left to be provided for by regulations to be issued by the Minister of Health, in order to give the government "plenty of elbow room to negotiate with the doctors" and to avoid the long debates in passage of the bill which inclusion in the measure of specific provisions on remuneration would undoubtedly have occasioned.

During deliberations on the bill, the method, rather than the amount, of remuneration received the greater attention. The attitude of the Labour party on this question had been revealed in 1943:

> The patient is not getting a service that is preventive, comprehensive, open to all, and fully efficient. In particular, the nation's resources of doctoring are ill distributed, and the doctor's conditions of employment do not adequately protect his own health, or his freedom as a guardian of health. In the Labour Party's opinion, therefore, it is necessary that the medical profession should be organized as a national, full-time, salaried, pensionable service.[9]

The case that is made for a salaried method of payment is based on the arguments that too keen competition for patients is derogatory to the medical profession and harmful to the welfare of the patient and that a capitation method of payment is likely to reflect a doctor's popularity and not necessarily his professional skill and merit. A salaried system would, it is argued, free the medical practitioner from financial anxiety to devote his full energies to the welfare of his patients.

Mr. Aneurin Bevan, the present Minister of Health, is not in complete agreement with these views, or at least does not consider that a full-salaried service is practicable at this time. He proposes a capitation method of remunerating the general practitioners plus a small element

[8] This claim is based on the required registration of every doctor by the General Medical Council, which passes on the professional qualifications of every doctor before he is permitted by law to practice.

The *Lancet*, January 18, 1947, considers as curious the claim that every registered general practitioner should be entitled as a matter of right to enter the public service: "Though to make the Act work no doubt every registered doctor will be allowed to participate, it would be difficult for *any* government to guarantee this in the wording of the Act. It would mean every doctor could compel the Minister to take him into the service. Such one-sided compulsion would not be tolerated by any government. It would be defensible only if the Minister had a complete monopoly of medical service, whereas under the Act, a doctor may practice outside."

[9] *National Service for Health: The Labour Party's Post-war Policy.*

of basic salary. Said Mr. Bevan in the House of Commons:

> Some [of the members of the Labour party] are in favor of a full-salaried service. I am not. I do not believe that the medical profession is ripe for it, and I cannot dispense with the principle that the payment of a doctor must to some degree be a reward for zeal, and there must be some degree of punishment for lack of it. Therefore, it is proposed that capitation should be the main source from which a doctor will obtain his remuneration. But it is proposed that there shall be a basic salary and that, for a number of very cogent reasons. One is that a very young doctor entering practice for the first time needs to be kept alive while he is building up his lists. The present system by which a young doctor gets a load of debt in order to practice is an altogether evil one.[10] The basic salary will take care of that. Furthermore, the basic salary has the additional advantage of being something to which I can attach an increased amount to get doctors to go into unattractive areas. It may also—and here our position is not quite so definite—be the means of attaching additional remuneration for special courses and special acquirements.[11]

To this proposal the British medical profession—or at least the more articulate members of the profession—have been resolutely opposed. They insist that the freedom of both patient and doctor depends on the employment of the doctor by the patient and payment by him or, in a public service, for him by means of a capitation fee; that directly the doctor is paid even a basic salary along with capitation fees, he and the patient both recede from a position of freedom; that instead of the doctor's whole interest lying with the patient, a second interest is introduced, namely, the body which employs the doctor and pays his salary.[12]

In addition to the argument that a salaried doctor in the public service will become the servant of the state rather than of the patient, it is also contended that a method of payment based on capitation would be more precisely related to a doctor's ability and initiative, whereas a salaried system would not provide the degree of income differentiation necessary to sustain keenness and efficiency; that, under salary, competition for patients would give way to competition to avoid them; and that a salaried method more or less fixes a ceiling on the earnings of a doctor. A method of payment which employs even a small element of basic salary, as proposed by the Minister, is looked upon with suspicion as the thin edge of the wedge that will ultimately open the way to full salary.

The extension of group practice, which will be encouraged under the act by the establishment of health centers[13]

[10] The sale and purchase of the "good will" of medical practices is an almost universal custom in England. Most doctors at the outset of their careers are compelled to purchase a practice, and many are forced to borrow funds in order to do so. Many doctors have come to rely on the sale price of their practices for retirement. Under the National Health Service Act, the buying and selling of practices in the service will be prohibited.

[11] *Parliamentary Debates*, April 30, 1946.

[12] The following explanation appeared in an undated mimeographed circular, "Whole Time Medical Service: Yes or No?" issued by the British Medical Association: "If it is arguable that when the community (i.e., the State) pays the doctors, it has the right to direct *where* they shall work, then the assumption is that it can also direct *how* they shall work. This could mean that it has the right to supervise the issue and duration of medical certificates (for benefits under other branches of the nation's social security program) to suit the state of Treasury funds. The whole freedom of the profession is menaced by this claim to control by the State, and with it is menaced the freedom of the individual to look to his doctor for personal service, given with the single aim to help him to keep well and to get him better when he is ill, and in no way influenced by pressure from the State to get him off the 'sick benefit list' as quickly as possible."

[13] Health centers will consist of technically equipped premises, constructed and staffed at public expense, to provide consulting rooms and other facilities where general practitioners and dentists may see their patients. They will also be used for the operation of special clinics, as outposts for certain hospital and specialist services and as bases for health-education programs. For doctors

throughout the country, is not expected to be conducive to a system of remuneration based on capitation. The competition engendered by a capitation method of payment will, from all indications, be aggravated in group practice such as is contemplated in the new health centers and may seriously undermine the cooperative spirit which is considered essential to the success of this form of medical practice.[14]

Considerations such as these had induced the Coalition Government, while not believing that "a universal change to a salaried system was necessary to the efficient development of the service," to suggest that "there will be parts of the new service to which different considerations will apply." It was therefore proposed that "normally, the remuneration of a doctor in separate practice will be based [as it is now in National Health Insurance] on a capitation system," but that "doctors practicing in Health Centers shall be remunerated by salaries or on some basis other than of capitation fees" and that "it would be possible, if desired by the doctors themselves, to offer remuneration by salary or on some similar basis to doctors engaged in group practice, even where the practice was not conducted in a Health Center and, perhaps, in certain circumstances, to doctors engaged in separate practice."

Method of remuneration cannot be divorced entirely from rate of remuneration.[15] In February, 1945, an interdepartmental committee of four doctors and four laymen under the chairmanship of Sir Will Spens was appointed by the Minister of Health to consider "what ought to be the range of total professional income of a registered medical practitioner in any publicly organized service of general medical practice."[16] The committee reported in May, 1946.

Determination of the amount of remuneration of general practitioners has

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who choose to conduct their practices in these centers, considerable co-operation will be involved in sharing common duties and work schedules, medical assistants, nursing and clerical staff, and common usage of physical equipment, waiting-rooms, and other facilities.

[14] There is at least one indication that the doctors themselves may come to favor a salary method of remuneration in health centers. In a public opinion poll conducted in 1944 among members of the British medical profession by the British Institute of Public Opinion with the support of the British Medical Association, 15 per cent of the more than twenty-five thousand doctors replying to the questionnaires voted for straight salary as compared with other methods of remuneration for doctors in individual practice outside of health centers, while 28 per cent favored straight salary for general practitioners conducting their practices in health centers.

[15] An editorial comment in the *Economist* (May 18, 1946) expressed the view that panel doctors under the National Health Insurance program have been grossly underpaid and that much of the opposition to the National Health Service Act and to Mr. Bevan's proposals with respect to remuneration may be due to this factor. The editorial pointed out that in 1937 "it was estimated that on the average each [National Health Insurance] panel patient received just over five items of service from his doctor in a year. Thus the doctor received less than 2*s.* for each item of service [the capitation rate at that time was 9*s.*] whereas his remuneration from each item of service to a private patient might vary from 5*s.* to 10*s.* 6*d.*"

Evidence was also submitted to the Spens Committee (established to study the remuneration of medical practitioners) to the effect that income derived from insurance patients comprised one-third of a doctor's total, while it consumed two-thirds of his time.

[16] While the terms of reference of the Spens Committee did not include the method of payment but only the range of the amount, the committee stated in its report that it had found to its satisfaction "that there is far greater diversity of ability and effort among general practitioners than admits of remuneration by some single scale applicable to all." While the report did not declare with certainty that the capitation method is necessarily the best for securing income differentiation according to ability and effort, it did state that "the evidence put before us showed that capitation affords a method of differentiation which is acceptable to the majority of the profession."

an important bearing on several aspects of the organization of a public service. It must be sufficiently high to maintain "the proper social and economic status of general medical practice and its power to attract a suitable type of recruit to the profession," as well as maintain the attraction of the public service as compared with private practice. There is also another consideration:

> In the past, many young doctors have been deterred from becoming specialists by the considerable risks and by the practical certainty of a number of lean years if they attempted to do so. In a comprehensive public service it is inevitable and right that the risks and lean years will present a less formidable deterrent. A much increased menace to the recruitment of general practitioners in the future will lie, in our judgment, in the competition of other branches of medicine than general practice. We, and not the least our lay members, consider that it would be disastrous to the profession and to the public if general practice were recruited only from the less able of the young doctors. We consider, however, that unless the financial expectations in general practice are substantially improved the great majority of the abler men will seek to become specialists, in view of the fact that as specialists they have an equal outlet for their interests in medicine, can more easily keep close contact with hospitals and with medical progress and will have a less arduous life.[17]

The Spens Committee emphatically held that the pre-war level of incomes for general practitioners was far too low. It found, for example, that for a three-year period prior to 1939, almost 20 per cent of the general practitioners between forty and fifty-five years of age received net incomes (gross income minus professional expenses allowed for income tax purposes) below £700, and over 40 per cent under £1,000. The proportion of practitioners able to achieve incomes between £1,600 and £2,000 was 10 per cent; 9 per cent earned over £2,000.

The committee recommended that the income level should be adjusted so that approximately half the general practitioners in their forties should receive incomes of £1,300 and over, and three-quarters over £1,000. According to the committee's estimates, this recommendation could be put into effect at an average cost per patient in the public service of 15*s*. 6*d*. in terms of 1939 money values.[18] By way of comparison, the capitation rate under the National Health Insurance program before the war was 9*s*.[19]

CONTROL OVER THE DISTRIBUTION OF DOCTORS

A method which Mr. Bevan, the Minister of Health, refers to as "negative control" was decided upon to insure even

[17] *Inter-departmental Committee on Remuneration of General Practitioners* (Cmd. 6810) (1946), p. 5.

[18] While the rate of remuneration recommended by the Spens Committee may satisfy the financial requirements for attracting suitable recruits to the profession, it will, if adopted, have a serious effect on the total cost of the program as estimated by the government and may exert considerable influence on the comparable level of incomes of the various professions. Commented the *Economist* (May 18, 1946): "The Committee's recommendations were in terms of 1939 money values. A capitation fee of 15*s*. 6*d*. in 1939 would roughly equal 23*s*. 3*d*. at today's prices. Multiplied by 45 million patients this would make a total cost of about £52 million for general practitioners' pay alone, whereas the estimate given in the Financial Memorandum to the Health Service Bill of the whole cost of the general medical services, including the general practitioner, pharmaceutical, dental and supplementary services, was only £45 million . . . . there is no doubt that if these recommendations are carried out there will, as Sir Ernest Fass points out in a rider to the report, be a wider gulf between the medical and other professions. The Spens Report should serve as a warning of the cost involved for the State if those working in public service are paid according to their merits."

[19] Following publication of the Spens *Report*, a series of negotiations between the medical profession and the Minister of Health resulted in raising the National Health Insurance capitation fee to 15*s*. 5*d*.

distribution of the general practitioners throughout the country,[20] the broad purpose of which is to prevent doctors who enter the public service after the date it begins from taking up their practices in localities where the supply of general practitioners is deemed adequate.

The mechanism by which this is to be achieved consists of newly created local bodies called "executive councils,"[21] one of which will be appointed for each county or county borough (or, at the Minister's discretion, for two or more), and the Medical Practices Committee,[22] a new central body to be appointed by the minister. The function of the executive councils in contracting with general practitioners for their services in the new program has been mentioned. Doctors practicing in any locality when the act takes effect will be entitled to participate in the service in that area if they wish to do so at that time. Once the scheme has begun to operate, however, a doctor who wishes to join the public service or, if he is already participating in it and wishes to practice in a different area, will be required to obtain the consent of the central Medical Practices Committee.

Under the Minister's regulations controlling new appointments, executive councils will be required to report periodically to the Medical Practices Committee on the number of doctors they require to fill the needs of their respective localities. They will also notify the committee of the occurrence of any vacancies appearing on their lists. When a vacancy occurs or when there is need for an additional general practitioner in a given area, the Medical Practices Committee will select an applicant from among the doctors applying for a practice in that particular locality after consultation with the local executive council, which will, in turn, be required to secure the views of the local medical committee (representing the local medical profession) on the person to be chosen. The only basis for refusal of an applicant by the Medical Practices Committee will be that the number of practitioners in the area requested by the applicant is already considered adequate.[23]

One of the first consequences of the plan to redistribute the general practitioners through this system of "negative

[20] In the House of Commons (April 30, 1946), Mr. Bevan cited the following illustrations of the present uneven distribution of general practitioners: ". . . . in South Shields before the war there were 4,100 persons per doctor; in Bath 1,590; in Dartford nearly 3,000 and in Bromley 1,620; in Swindon 3,100; in Hastings under 1,200." Mr. Arthur Greenwood, the Lord Privy Seal under the Labour Government, stated that in one section of Bristol comprising a population of 34,000 working people, there was no resident doctor, while in the near-by seaside residential town of Taunton with approximately 40,000 persons, there were 56 resident general practitioners.

[21] One-half of the members of executive councils will be professional, appointed by the general medical and dental practitioners and pharmacists through their local representative committees; the other half will be chosen by the local health authorities (county or county borough councils) and the Minister of Health: (*a*) a chairman and 4 members appointed by the Minister; (*b*) 8 members appointed by the local health authority; (*c*) 7 members appointed by the local medical committee; (*d*) 3 members appointed by the local dental committee; (*e*) 2 members appointed by the local pharmaceutical committee.

[22] The Medical Practices Committee will consist of a chairman who must be a medical practitioner and 8 other members, of whom 6 must be medical practitioners, at least 5 of whom are actively engaged in practice.

[23] Consent to practice in a particular locality may be given outright or may be made subject to the condition that the applicant be excluded from practicing in a specified portion or portions of the locality in which he is interested. A doctor whose application is refused, or granted subject to a condition, will have the right of appeal to the Minister. The Medical Practices Committee and, in appeal cases, the Minister will be required to give consideration to the wishes of the applicant to engage in group practice with other practitioners and to the wishes of the group practitioners themselves. Special regard must also be paid to family relationships.

control" was the decision by the government to abolish the buying and selling of the "good will" of medical practices, on the grounds that proper distribution of the doctors would be impossible under a system which permitted the sale and purchase of medical practices. Moral reasons were also given:

> Proper distribution kills by itself the sale and purchase of practices. . . . . I have always regarded the sale and purchase of medical practices as an evil in itself. It is tantamount to the sale and purchase of patients. Indeed, every argument advanced about the value of the practice is itself an argument against freedom of choice, because the assumption underlying the high value of a practice is that the patient passes from the old doctor to the new. If they did not pass there would be no value in it.[24]

For the loss incurred by general practitioners due to the prohibition of the sale of their practices, compensation will be paid to those practitioners who enter the public service by the date that the act becomes effective, presumably April 1, 1948.[25] A contributory superannuation scheme for the medical profession will also be established under regulations to be issued by the Minister of Health, which will, in the future, provide for those doctors who, under present conditions, must depend on the sale of their practices for retirement. Doctors who join the public service after the date when the act takes effect will not qualify for compensation for the loss of the right to sell their practices. Those who remain outside the service will, as at present, retain the right of sale.

It is important to note that the proposals of the Coalition Government in 1944 were not essentially different with respect to the distribution of general practitioners. They contemplated a general-practitioner service administered by a central medical board, composed largely of professional persons with some lay representation, appointed by the Minister of Health and acting under his direction. This board was to be the "employer" of the doctors who entered the service, whether they were to be engaged in separate practice or in group or health-center practice. Since the provision, staffing, and maintenance of health centers was to be a responsibility of local authorities (county or county borough councils), a voice in the employment of doctors was to be given these authorities by a provision that the doctors in the centers would be appointed jointly by the Central Medical Board and the local authority, with the doctor's terms of service centrally negotiated and settled. Termination of the doctor's service in the centers would also be by joint decision or, if the board and the authority failed to agree, by the Minister. The board was to have the responsibility of watching over the distribution of general practitioners under a plan whereby consent to practice in a given area would be refused when the number of doctors in that locality was considered adequate.

The Coalition Government did not, however, propose to abolish the buying and selling of medical practices in the public service, at least at the outset of the scheme:

> The Government have not overlooked the case which can be made for abolishing the

[24] Speech by Mr. Bevan at second reading of the bill, *op. cit.*, April 30, 1946.

[25] Compensation is to be paid from the "global" sum of £66,000,000 which was appropriated for this purpose, to be apportioned among the general practitioners of England, Wales, and Scotland under regulations to be issued by the Minister of Health. If the initial number of general practitioners who enter the service by the date the act becomes effective falls substantially below the anticipated 17,900, this sum will be reduced under statutory provision. Normally, the amount finally decided upon plus interest at the rate of 2¾ per cent will be payable at the retirement or death of a practitioner except where special hardship may require earlier payment.

sale and purchase of publicly remunerated practices. The abolition would involve great practical difficulty and is not essential to the working of the new service, and the Government intend to discuss the whole matter further with the profession, including any measures which may be needed to prevent the operation of the new service from itself increasing the capital value of an individual practice, and therefore also the compensation which may later have to be paid [Cmd. 6502].

The White Paper drew attention to several practical obstacles to the retention of the right of sale of all public practices. One related to public practices in "overdoctored" areas, the continuance of which the Central Medical Board could not approve. In such cases the outgoing doctor would lose the right of sale, and compensation for this loss was therefore proposed. It was also considered that it "would be incompatible with the conception of the Health Center that practices within the Center should be bought and sold and a doctor will therefore, by entering a Center, exchange a practice having a realizable value for a practice which he will be debarred from selling." The solution to this problem was not clear. Reference was made to the superannuation rights and "other facilities of considerable value" which the doctor entering a health center would exchange for loss of the right to sell his practice, plus some compensation: "The proper course will be to strike a fair balance between what he gains and loses and to compensate him accordingly."

These obstacles to universal retention of the right of sale of publicly remunerated practices complicated proposals for provision of superannuation benefits on an equitable basis for those doctors who continued in separate practice and therefore, under the Coalition Government's plan, retained the right to sell their practices. For them the Coalition Government proposed "to consider whether an acceptable scheme can be devised for retirement within specified age limits for superannuation on a contributing basis."

It will be evident from this discussion of the arrangements of the government for distribution of the general practitioners, that the provisions of the act stand in direct opposition to the fourth principle of the medical profession's Negotiating Committee: *Doctors should, like other workers, be free to choose the form, place, and type of work they prefer without governmental or other direction.* The claim has been made that the general practitioners are not so maldistributed as might appear, if proper allowance is made for those doctors in retirement or semi-retirement in areas where the number of general practitioners seems to be relatively high.[26] The system of "negative control" is looked upon as direct control by the profession and as "an unjustifiable and unnecessary interference with the freedom of the doctor" because "any necessary improvement in the distribution of doctors can be achieved on the existing basis of general practice."[27] It is contended that removal of the financial barrier between the patient and the doctor in depressed areas, together with improvement in hospital and other medical-care facilities, will in themselves go a long way in correcting any maldistribution of the doctors without need for ad-

[26] "Doctors, on the whole, are not badly distributed. The Central Medical War Committee register has shown that in areas where there appears to be an undue number, a liberal discount has to be made for retired doctors and doctors who are themselves invalid and less active. The distribution of active doctors cannot be learned by taking the total number of doctors in a locality and dividing it into the population" ("The New Act; Dr. Dain's Speech at Exeter," *British Medical Journal*, November 16, 1946).

[27] *The National Health Service Act: Report of Negotiating Committee* (St. Albans: Gainsborough Press, November, 1946).

ministrative controls; and, if experience indicated the necessity for further readjustment, it should take the form of inducements, such as special compensatory capitation rates for understaffed areas.[28]

Much criticism has been leveled against abolition of the buying and selling of medical practices. The Negotiating Committee maintains "that the ownership of goodwill is essential to the continued freedom of the general practitioner" and regards its abolition "as a first and substantial step to a State salaried service." The Minister's charge of the immorality of the custom is also challenged:

> The Minister has made a great deal of this buying and selling as an immoral act, describing it as the transfer of large blocks of patients, which is a complete travesty of the position whereby goodwill only is transferred. And although it is "immoral" for a general practitioner to buy and sell his practice, it is not "immoral" for the consultant or the dentist[29] similarly to buy and sell.

Apart from opposition to the principle of abolishing the sale of practices, objections have been raised to some of the consequences of this prohibition and to the manner in which the sale of good will is to be terminated.[30] It has also been deemed unjust by the profession that doctors who do not join the service by the day on which the act takes effect will not qualify for compensation for loss of their right to sell if they should decide to join the service later. It is argued that general practitioners must make their decisions to join the service at the very outset of the scheme before a doctor has opportunity to learn the wishes of his patients. If he remains out of the service, he may eventually lose his patients to doctors participating in the scheme and, at the same time, forfeit forever his title to compensation. This is regarded as undue restriction of his freedom of choice.

ADMINISTRATIVE ORGANIZATION OF HOSPITAL AND SPECIALIST SERVICES

The present British hospital system is a curious mixture of some two thousand public hospitals under the control of democratically elected local authorities (county or county borough councils) and about one thousand voluntary (private, nonprofit) hospitals of various kinds, managed by their own individual governing bodies. The public hospitals are financed by local rates and taxes, while the voluntary hospitals are supported by private endowment, appeals to private charity, and payments for services. These voluntary hospitals, "established frequently at the caprice of private charity," have long been recognized as unevenly distributed over the country; frequently they bear little or no relation one to an-

[28] These proposals were made by Dr. Charles Hill, secretary of the British Medical Association, in a speech on May 5, 1946. See *B.M.J.*, May 11, 1946.

[29] The act contains no provisions prohibiting the buying and selling of good will by consultants and dentists, or for compensation for loss incurred by them.

[30] A series of definitions of offenses appear in the act designed to assure that a practice for which the state has paid compensation is not sold again to someone else. These definitions refer to such matters as the sale of a doctor's house to a general practitioner when the sale price is "substantially in excess" of what would have been realized had the house not been used for medical-practice purposes and to the unequal sharing of income in a partnership under certain specified conditions. These definitions the Negotiating Committee consider "so wide in their scope and so abstruse in their terminology as to be likely to be unjust in their application, despite the provision of some measure of protection by registration." (The act provides for the determination in advance by the Medical Practices Committee of whether a proposed transaction would be considered as the sale of the good will as defined in the act and, if not, for the issuance to the parties involved of a certificate to that effect as a safeguard against possible future charges.)

other. Often two near-by hospitals provide the same services unnecessarily, usually in the more affluent areas, while in other sections there is a shortage of hospital accommodation, especially in industrial and rural districts. Many of these hospitals are too small or too poor to provide the kind of general and specialist services required in modern hospital treatment. Similar variation is found among the public hospitals, where smaller and poorer local authorities have been unable adequately to discharge their hospital responsibilities.

This general condition of the nation's hospital services has led to repeated recommendations over a number of years by professional and lay bodies for the reorganization of the hospitals on a regional basis in order better to pool the resources of a given area and provide a modern, well-equipped, and planned service on a broader financial basis.[31] The Negotiating Committee followed similar recommendations of the British medical profession in formulating its sixth principle: *The hospital service should be planned over natural hospital areas centered on universities in order that these centers of education and research may influence the whole service.*

In the opinion of the Labour Government, the replanning and reorganization of the hospitals could not be accomplished effectively if a number of hospitals (that is, the voluntary hospitals) remained under the control of separate autonomous bodies. Furthermore, the financial status of many of the local governments would not permit the provision and maintenance of hospitals of modern standard and adequate size. Therefore, in order to "universalize the best" and to "provide every citizen in the country the same standard of service," the Labour Government decided to transfer all existing premises and equipment of both the public and the voluntary hospitals, including present endowments and other assets as well as existing liabilities of non-teaching hospitals,[32] to the Minister of Health to be reorganized on a regional basis into a single hospital service under the new scheme. The Minister is also empowered to acquire, by purchase if necessary, other hospital or medical institutions, together with their equipment if he considers them necessary for the new service.

Within the scope of the general regulations and any particular directions laid down by the Minister, the administration of these hospitals and the specialist services which will be attached to them will be intrusted to newly created regional hospital boards,[33] one for each of the hospital regions into which the Minister is authorized to divide the country in such a manner that the services in each region will conveniently be associated with a university medical school. Fourteen such

[31] *Report on the British Health Services* (1937) by P.E.P., is still regarded as perhaps the most important and comprehensive survey of this subject. It contains a detailed description of the problems of the voluntary and public hospital systems and recognizes the need for a regional basis of hospital organization and closer co-operation between the two systems for more effective use of the nation's hospital resources.

[32] A teaching hospital is defined in the act as any hospital or group of hospitals which provide facilities for university undergraduate or postgraduate clinical teaching and is designated as a teaching hospital by the Minister of Health. Thus it may include hospitals which were not teaching hospitals at the outset of the scheme.

[33] Each regional hospital board will be composed of persons appointed by the Minister of Health after consultation with the university with which the hospital and specialist services in the board's region are to be associated, bodies representative of the medical profession, the local health authorities in the region, and others concerned, including, in the beginning, organizations representative of the area's voluntary hospitals. At least two members of each board will be required to have had experience in mental hospital services.

hospital regions have been designated, arranged around eleven universities, London University being related to four regions.

In accordance with a scheme approved by the Minister, each regional hospital board will appoint local hospital management committees,[34] one for each of the larger hospitals or related group of hospitals forming a self-contained hospital unit in its region. The function of these committees will be to carry on the day-to-day management of the particular hospitals under their supervision, subject to any regulations which may be issued either by the Minister or the regional hospital boards. There will be separate administrative arrangements for the teaching hospitals, each under its own board of governors,[35] appointed by the Minister. Medical and dental schools will not be transferred either to the Minister or to the boards of governors of the teaching hospitals but will continue under their former governing bodies.

The endowments of the voluntary non-teaching hospitals will be deposited in a central hospital endowments fund to be established by the Minister of Health, under whose direction it will be controlled and managed. The assets of the fund will be used to discharge the existing debts and liabilities of the voluntary hospitals transferred to the Minister, and the remaining capital value of the fund will be reapportioned among the several regional hospital boards and hospital management committees. Income from the fund will be distributed to these boards and committees in proportion to their share of the capital fund, to be used at their discretion for hospital services or research, subject to any general conditions which may be prescribed. General financing of the hospital and specialist services, however, will be done by the Exchequer. Endowments of voluntary teaching hospitals will be transferred to the new boards of governors to be used at their discretion. As far as practicable, the original purpose and any attached condition to these endowment funds are not to be prejudiced.

Staffs of all hospitals in the service will be employed by the regional hospital boards or, in the teaching hospitals, by the boards of governors, subject to regulations of the Minister regarding qualifications, conditions of service, and remuneration. These regulations will be formulated by the Minister after consultation with organizations representative of the staffs concerned. Consultants and specialists participating in the scheme either whole- or part-time will be attached to the staffs of the hospitals. Participants will be free to engage in private practice outside the public service.

In hospitals with single bedrooms or small wards, the Minister is authorized to make these available for patients able and willing to pay the entire cost of private maintenance and attendance, provided that other patients do not require this space on medical grounds. For these latter patients it will be provided free. Specialists and consultants who are members of the staff of a hospital in the service, whether in an honorary or a paid capacity, will be permitted to treat their private patients in the "pay-bed" ac-

[34] Each hospital management committee will be composed of persons chosen after consultation with the principal local health authorities in the region, the medical and dental staff of the hospitals concerned, the executive councils responsible for the general practitioner services in the area, and the previous governing body of any voluntary hospital.

[35] The boards of governors of the teaching hospitals will include members nominated by the university with which the hospital is associated, the regional hospital board of the particular area, and the medical and dental teaching staff of the hospital. Others will be chosen after consultation with the local health authorities in the region and other organizations concerned, including, initially, any previous governing bodies.

commodations and to charge fees subject to a maximum scale governed by regulations of the Minister.

Despite the general agreement between the recommendations of the medical profession and the plans of the government to reorganize the hospital services of the country on a regional basis, several objections have been made by the profession to the hospital provisions of the act, even though the local authorities and voluntary hospitals, who are more directly affected, put forth no very strong or definite opposition.[36] One spokesman of the British Medical Association accused the government of creating a state monopoly in hospitals, free of competition from nonstate hospitals.[37] The Negotiating Committee, in its report on the act, conceded that the hospital provisions would create a strong regional organization, which the medical profession had long desired, but was apprehensive that the plan would "tend to destroy local interest and initiative and so affect adversely the capacity of a hospital for innovation and experiment, its power to attract nursing and other staff and the confidence of the local people in their local hospital."

The feature of the hospital plan most objectionable to the medical profession, however, is the control it will afford the state over some branches of the medical profession, namely, the specialists and consultants. When all the hospitals have been transferred to the Minister of Health, not only will he administer them through the new regional hospital boards of his own choosing, but he will also have the power to lay down the terms, conditions of service, and the qualifications of the personnel who will work in them, including the doctors. Also, specialists will be permitted to attend private patients in the hospitals only if they are at least part-time or honorary members of the hospital staff. It is the contention of the medical profession that, under these conditions, all consultants and specialists will become state servants and that it will spell the end of independent private consulting practice. While it is true that private nursing homes, where available, will be open to the independent specialists, their facilities will probably be extremely limited, and they will also be subject to acquisition by the Minister if he deems them necessary for the public service.

Under the 1944 proposals of the Coalition Government, the control of the public hospitals was to remain under the local authorities as heretofore, although where necessary these authorities were to be combined into "joint authorities." The present powers and duties of the local authorities were to be transferred to these joint authorities who were to take over and manage the publicly owned hospitals in the consolidated areas. The newly combined areas were to be decided upon by the Minister of Health "after consultation with local interests at the outset of the scheme." Each joint authority was to prepare "a plan of hospital arrangements for the area, based on using, adopting and when necessary supplementing existing resources." This plan was to be subject to the Minister's approval. The voluntary hospital system was to remain intact with the joint au-

[36] The principal opposition which did arise from this source concerned the transfer of the hospital endowments funds, which total £32,000,000, on the ground that the original purposes and attached conditions of these endowments will be prejudiced. In reply to this argument, the Minister of Health contended that the funds were donated for hospital purposes and will be so used: after payment of the liabilities of the voluntary hospitals, the capital value of the fund will be reapportioned among them, which they may use at their own discretion over and above the funds provided by the state.

[37] This charge was made by Dr. Charles Hill, *op. cit.*

thorities responsible for negotiating contracts with those voluntary hospitals which could be prevailed upon to enter the new service in order to supplement the public hospital facilities, for which they would receive service payments from the joint authority in accordance with centrally determined scales.[38] Consultant and specialist services were to be provided in conjunction with the hospital services, partly under the direct responsibility of the joint authorities and partly of the contracting voluntary hospitals. Terms and conditions of work for the specialists and consultants were to be matters for individual hospital negotiation, but "in order to avoid anomalies as between hospital and hospital and between area and area some central regulation of remuneration will be required."

PROFESSIONAL AND DEMOCRATIC CONTROL OF THE SERVICE

As provided under the British National Health Service Act, the new medical services will be divided into three branches, organized on central, regional, and local levels of government, with over-all responsibility and authority concentrated in the Minister of Health. The three branches of the service will be the hospital and specialist services, organized on a regional basis; the general medical, dental, and supplementary ophthalmic services, administered under a combined local and central authority; and the health center and supplementary services, provided by the local authorities.

On the central level of administration, the Minister of Health will be assisted by a central health services council to advise on technical and professional matters relating to the service.[39] This council will consist of forty-one members, all of whom, with the exception of six ex-officio members, will be appointed by the Minister. Over half the members of this body will be professional.

The administration of the hospital and specialist services through the regional hospital boards appointed by the Minister, and the hospital management committees appointed by the regional hospital boards has already been described, as has the administration of the teaching hospitals through the boards of governors of the teaching hospitals, which will also be appointed by the Minister. While the exact proportion of professional representation on the regional hospital boards and hospital management committees is not specified in the act, consultation with members of the medical profession, among other groups, will be required before final appointments are made. In the case of the boards of governors of the teaching hospitals, not over one-fifth of the members will be nominated by the medical and dental teaching staffs of the hospitals concerned.

The medical profession will also be represented on the central Medical Practices Committee and the executive councils, which will administer the general medical, dental, and supplementary ophthalmic services. Of the nine members on the Medical Practices Committee, all appointed by the Minister, seven must be medical practitioners; of the twenty-five members of each executive council,

[38] These service payments were to be less than the total cost of the services rendered on the ground that "if the voluntary system is to be maintained, the voluntary hospital will still rely in large measure on its own resources, personal benefaction and on the continuing support of all who believe in the voluntary hospital movement."

[39] The central health services council will be composed of 6 ex officio members who are the presidents of the principal British medical bodies; 15 medical practitioners; 5 persons experienced in hospital management, not medical practitioners; 5 persons experienced in local government, not medical practitioners; 3 dental practitioners; 2 persons experienced in mental health services; 2 registered nurses; 1 certified midwife; 2 registered pharmacists.

ten will be appointed by the general medical and dental practitioners in the given locality.

One other important central administrative body, the tribunal,[40] is to be set up to investigate charges that the continued inclusion of any doctor, dentist, optician, or pharmacist in the public service "would be prejudicial to the efficiency of the service." One of the three members of the tribunal must be professional.

Thus it would at first appear that the new National Health Service will meet the requirements of the Negotiating Committee's last principle: *There should be adequate representation of the medical profession on all administrative bodies associated with the new service in order that doctors may make their contribution to the efficiency of the service.* On the contrary, however, some of the most severe criticisms of the new scheme have been made in this regard both by the medical profession and by the Conservative party.

The opposition of the profession is not based on inadequate proportion of representation but on the fact that on all important administrative bodies the Minister has power to appoint the members and to alter the constitutions of the bodies and that, in almost all instances, the Minister is merely required to consult with the profession before making appointments. There is nothing to compel him to listen. What the profession had desired was the power of nomination, but this principle was followed only in the selection of a small portion of the membership of the boards of governors of the teaching hospitals. In only one body (the executive council), will the profession directly appoint any of the members.

The professional and political opposition to the administrative organization of the service involves more than the matter of nomination and appointment of administrative bodies. It concerns principally the highly centralized organization of the entire scheme. Not only will the Minister appoint the more important administrative bodies, but he will also determine by regulations and orders[41] a wide variety of matters not prescribed in the act, such as the constitution, functions, conditions, and manner of operation of several of the administrative bodies; the tenure and vacation of office and rates of payment of their members; the areas over which they will have jurisdiction and the extent to which they will consult with other bodies, representatives of professional organizations and local committees, and other groups which may be concerned. All

[40] The tribunal will consist of a chairman, who must be a practicing barrister or solicitor of at least ten years' standing, appointed by the Lord Chancellor; one person appointed by the Minister after consultation with representatives of the executive councils; and a third member, who must be of the same branch of the profession as the person under investigation and drawn from a panel of six persons of the several branches of the profession, all appointed by the Minister. Where the tribunal finds the charges to be justified, the local executive council will be required to remove the person's name from its list. A practitioner so disqualified will have the right of appeal to the Minister.

[41] *Regulations* promulgated by the Minister under the act are subject to parliamentary control in either of two ways: (1) by affirmative control, under which the regulations are ineffective until approved by the House of Commons; (2) by negative control, under which the regulations are required to be laid before Parliament when issued, at which time they become operative at once and, unless Parliament within forty days resolves their annulment, have the effect of statutory law.

Orders, however, are not subject to review by Parliament in either of the two ways applicable to regulations unless there is a specific provision in the act to the contrary. Some orders are to be subject to negative resolution, while others will not be reviewed formally at all. Powers included in the latter group are the constitution of the regional hospital boards, the designation of teaching hospitals and constitution of the boards of governors, and the exercise of default powers over the local health authorities or any of the other several bodies constituted under the act.

bodies which are required to prepare plans for discharging their responsibilities under the scheme, such as the regional hospital boards and the local health authorities, must submit them to the Minister for approval. What is more, the Minister is vested with default powers under the act, which give him control over the execution and administration of the plans which he has sanctioned: when a body defaults in its obligations, he may reconstitute it or, if it is a local health authority, take over its functions directly.

The pledge inherent in the new British National Health Service, that opportunity for the best possible medical care the nation's resources afford shall be equally available to every person in every part of the country, is the government's justification for the strong central control with which the scheme will be organized. It is the Labour party's philosophy that ultimate responsibility and authority for successful inauguration and effective operation of the new service should rest with one responsible central authority, the Minister of Health, subject, of course, to the general control of Parliament. The powers granted the Minister under the act were designed to be commensurate with that responsibility.[42]

In recognition of local autonomy and initiative, it is the intention of the government that the several administrative bodies shall enjoy as high a degree of independence in their own jurisdictional areas as the general concept of a nationally organized and nationally financed service permits. The government believes that, within the limits prescribed by the broad powers of the Minister, there will be ample opportunity for local initiative, individuality, and experimentation. It is anticipated, for example, that the local health authorities will be given wide latitude in the development of the general medical and domiciliary services to satisfy local peculiarities and desires, provided that the services supplied meet the medical needs of the area and fit into the general over-all scheme for the entire country.

Criticism of the highly centralized organization of the new program pervades practically every argument of those opposing the plan and dominates the major objections raised by the medical profession. As one doctor expressed it in a letter to the British Medical Association:

> The Bill, soon to become law, contains many provisions that are good; and so the scheme no doubt appeals in various ways to some individual members of the many sections of our profession. Thus the young doctor will welcome the prospect of not having to buy a practice; others will look with favor upon a certain security of tenure, while the young man anxious to specialize will see in it a chance to acquire and practice a specialty without enduring years of penury. But surely these considerations are beside the point. The kernel of the matter, as far as the profession is concerned, is centered in this business of control. Initially, the conditions of service may appear rosy, but who will make these conditions or alter them as time goes on? If we find regulations concerning salaries or hours of work not to our liking to whom shall we appeal for redress? The government and

[42] "The nation's most precious asset—its health—is to be insured by the entire nation. So the nation must have, amongst other services, a state medical service, which is sensibly planned so as to make the very best use of all the nation's medical resources for the benefit of all.

"There must, therefore, be some central health authority, competent to plan the health services as a whole, including the medical service, subject to the general control of Parliament, and competent to see that the plan is carried out, with due allowance for the diversity of local conditions. . . . .

"The central authority can only be the Minister of Health. No other authority has the Ministry's accumulated knowledge of national health conditions; nor could any other organization less nationwide in scope be held responsible to Parliament. In a matter which so vitally concerns the whole nation, it is Parliament, representing the whole nation, which must have ultimate control" (from *National Service for Health: The Labour Party's Post-war Policy*).

control of hospitals and of the doctors will be in the hands of nominees of the Minister.

Let each one in our profession, specialist or general practitioner, examine individually this aspect of the Bill as far as he himself is concerned. . . . . As this matter of control overshadows the other provisions of the Bill, I consider that it is in this issue that the British Medical Association should mainly base its propaganda.[43]

Dr. Charles Hill, secretary of the British Medical Association, asked shortly after the introduction of the bill in Parliament:

Does our experience lead us to believe that the State as we know it today is so wise, so omniscient, so providential a depository of human wisdom as to justify the handing over to it in their entirety the hospital and personal health services of the country? My experience with our Civil Service is that it is headed by men of great ability and incorruptible integrity but with sometimes just a slight lack of elasticity. Won't our medical services be submerged by administrative regulations and control?[44]

The main divergence between the proposals of the Coalition Government and the plan adopted by the Labour party lies in this matter of central control. The Coalition Government's plan was based on the principle that existing systems and administrative practices were to be disturbed as little as possible without incurring serious inconsistencies in so comprehensive a scheme. "The problem of creating a national health service is not that of destroying services that are obsolete or bad and starting afresh, but of building on foundations laid by much hard work over many years and making better what is already good."[45] It was therefore proposed to "close the gaps," while adhering to "the principle of local responsibility . . . . the principle already adopted in the majority of the health services in the past." Central control was to be imposed only on the most stubborn administrative problems which would yield to no other practicable solution:

To uproot the present system and to put into the hands of some central authority the direct administration of the new service, transferring to it every institution and every piece of present organization, would run counter to the whole historical development of the health services; and from a practical point of view a step of this kind would certainly not contribute to the successful and early introduction of the new service. Changes, some of a drastic kind, will be necessary. . . . . But there is no case for departing from the principle of local responsibility coupled with enough central direction to obtain a coherent and consistent national service.

Central responsibility, in the Coalition Government's plan, was to be placed in the Ministry of Health as the only "arrangement possible, having regard to the magnitude of the scheme and the large sums of public money that will be involved." However, only one part of the proposed scheme—the general-practitioner service—was to be, in the main, centrally administered in the interest of even distribution of the general-practitioner services. Local administration for the other services was to be preserved as far as practicable through the county and county borough councils, although some services—the hospital and consultant services—were to be under joint authorities, with the county and county borough councils comprising the constituent bodies in the new combined authority for the consolidated areas. These joint authorities were to include all local services in their general plans for the area under their jurisdiction; after approval of these plans by the Minister of Health, determination was to be made in each separate area as to which of the services were to be provided and operated by the local

[43] Letter by K. M. MacDonald, *B.M.J.*, November 16, 1946.

[44] Speech by Dr. Charles Hill, *op. cit.*

[45] *A National Health Service: The White Paper Proposals in brief*, p. 4.

authorities and which by the joint authorities. The proposals of the Coalition Government did not appear to include empowering the Minister to reconstitute inefficient or delinquent administrative bodies similar to the default powers under the Labour Government's act.

These major differences between the Coalition Government's proposals and the provisions of the British National Health Service Act prompted the chairman of the Council of the British Medical Association to remark in an address the day after the act received royal assent:

> The Act is part of the nationalization program which is being steadily pursued by the Government. What the Minister appears to have done is to have taken the Bill which we had partly fashioned (under the Coalition Government) and to have inserted into it the Socialist principles of State ownership of hospitals, direction of doctors,[46] basic salary for doctors, abolition of buying and selling of practices. . . . .
>
> By these powers he becomes the complete medical service dictator. He may use his powers beneficially, but we have seen a number of Ministers of Health during the last twenty years, and we know that the wisdom and beneficence of one Minister is not necessarily inherited by his successor. During the passage of the Bill through the House of Commons he opposed every attempt to limit his powers by saying that it was essential for the flexibility of the service that he should be able to make modifications when he thought necessary. . . . .[47]

The reaction of the opposition government was equally severe. The Rt. Hon. J. S. C. Reid, Conservative member from Glasgow, in the House of Commons, asked:

> Why is so much being left to regulations? Why is the House being asked to give the Government a blank check in matters of such enormous importance? . . . . Why is there all this centralization and this preference for centralized power against decentralized administration and responsibility? Is it just grasping after power or is it some belief that uniformity and efficiency are the same thing? I cannot see any third reason to justify this aggregation of powers and duties at the center, and I hope the Minister will be able to tell us why the Government have adopted this highly bureaucratic and, indeed, totalitarian method of approach.[48]

To these questions the Minister of Health had already given his answer two days previously, when, in the course of his speech opening the Second Reading of the Bill, he had said: "The practical difficulties of carrying out these principles and services are very great. When I approached this problem, I made up my mind that I was not going to permit any sectional or vested interests to stand in the way of providing this very valuable service for the British people."[49]

SUMMARY AND CONCLUSIONS

The general objectives of the new British National Health Service, which will begin some time in 1948, have had the widespread backing and support of all segments of the British population, including all political parties and the medical profession. The comprehensive character of the new service, which includes dental and optical care, and their availability to the entire population free of charge have been noncontroversial. Many of the principles and methods adopted by the present Labour Government in arranging to put the scheme into operation have likewise found general agreement. From the patient's standpoint, these include freedom to use the new service or to arrange for medical care privately at his own expense; freedom to

[46] This charge is not quite clear, since the Coalition Government's proposals included a system of control over the distribution of general practitioners similar to the "negative control" of the Labour Government's scheme.

[47] "The New Act," Dr. Dain's Speech, *B.M.J.*, November 16, 1946.

[48] *Parliamentary Debates*, May 2, 1946.

[49] *Ibid.*, April 30, 1946.

choose the doctor in the service by whom medical care will be provided and to change panel doctors for any reason; and also freedom to consult a private doctor, at the patient's own expense, while retaining the right to continue use of the public service. For the doctor's part, there will be freedom to enter the public service or to continue in private practice; to accept or to refuse the care of patients applying for inclusion on his list; and professional freedom in treating a patient. Doctors may also participate in part-time service in the new scheme while continuing private practice.

Some aspects of the organization of the new program have also occasioned little controversy. The reorganization of the nation's hospital services on a regional basis, grouping them around universities and centers of research, has been advocated by both professional and lay bodies. The necessity for local provision of domiciliary and supplementary services was generally accepted. So also was the provision of the new health centers and the fostering of group practice, although there is some divergence of opinion on the part of the medical profession regarding the extent to which health centers should be employed at the outset of the scheme without experiment with their effectiveness and acceptability. The need for active participation by the medical profession in planning and operating the new program and the necessity for some degree of central co-ordination combined with ample opportunity for local participation have also been recognized, although considerable differences of opinion exist between the government, the medical profession, and the opposing political parties on the degree of each that is both necessary and practicable.

Four major areas of disagreement have arisen in planning the new service: the method of remunerating the doctors; the system of "negative control" to assure even distribution of the general-practitioner services, together with the abolition of the buying and selling of medical practices; the transfer of the voluntary hospitals to the government and the control that it is alleged this transfer and the arrangements for the specialist services will exert over private consultant and specialist practice; and the high degree of centralized control of the new program.

These difficulties arise out of the very nature of the new medical program. For instance, once a nation seriously decides to provide comprehensive medical care to its entire population, it must be assumed that available and adequate services are to be accessible to everybody if the scheme is to be effectuated. This immediately raises the difficult question of how to distribute the doctors over the country so that there will be an adequate supply in the rural and depressed areas, while avoiding an overconcentration of doctors in more attractive regions. Both the Labour Government and the Coalition Government were in agreement that administrative control would be necessary to achieve this objective, and both proposed a method whereby doctors in the public service would be refused consent to practice in overdoctored areas. Even under this system it will be a considerable time before the more remote regions are adequately staffed, even though the system will be coupled with special remuneration to attract doctors to these areas. It appears doubtful that improvement of medical facilities throughout the country and removal of financial barriers between the doctor and patient alone, as proposed by the medical profession, would result in equalizing the distribution of general practitioners to the extent required for assurance of adequate medical care for everybody.

A system of special payment rates, without administrative control over the movement of doctors, in order to entice doctors into the remote regions, gives no guaranty that the doctors will move to those areas. There are also financial considerations. The level of inducement payments, to be effective, might have to be so high that the cost of the program would be increased exorbitantly, while, if young doctors entering the service are to be given some financial guaranty while building up their lists and at the same time are permitted to remain in over-doctored areas, further expense would be added to the cost without contributing to the solution of the problem of providing adequate service in understaffed areas.

The method of remunerating the doctors is another problem inherent in a comprehensive medical-care program of this kind. The medical profession insists on a straight capitation method of payment. It is highly questionable whether it would be possible to apply such a method universally. Even if it is granted that a salaried or part-salaried system might lead to governmental interference in professional practice or weaken professional efficiency, young doctors entering the public service can be supported during the period they are building up their lists only by some minimum financial guaranty (basic salary) or by continuance of the buying of practices, against which there is considerable argument. Capitation methods of payment in group practice, as in the health centers, will admittedly be exceedingly difficult, if possible at all. It appears, therefore, that at least for some branches of the profession a salaried or part-salaried method of payment would have been found necessary, even though not necessarily universally applicable.

There are strong arguments for the abolition of the buying and selling of publicly remunerated medical practices. The Coalition Government, which proposed retaining the custom, recognized its difficulties, such as in the case of the abolition of a medical practice in an over-doctored area which automatically destroys the right of sale. More serious, however, is the question of increasing the value of medical practices by providing free medical care at public expense; these increased values would accrue to the doctors while at the same time acquisition of a practice by new members of the profession would become increasingly difficult because of higher cost.

It is difficult to say whether adequate, even, and economical distribution of available hospital accommodations could be achieved without transfer of the voluntary hospitals to the government. Both the plan of the Labour Government and that proposed by the Coalition Government involve serious perplexities. The Coalition Government plan, which would have continued the present voluntary-hospital system, would have given no assurance of even distribution of the hospital resources of each region, while it would have continued some of the recognized weaknesses of that system, such as the uneven quality of these hospitals, their unequal ability to meet modern standards of service, and the waste of resources in unnecessary duplication of hospital services, which now becomes a more serious problem than ever in face of the severe economic crisis through which the country is passing. At the same time, the increase of public funds allocated to these hospitals would have considerably reduced their "voluntary" character, while remaining under private control. Co-ordination of the two systems on a regional basis would

probably have continued to be a serious difficulty.

It cannot be denied that the British National Health Service plan, as finally adopted, is a highly centralized scheme with concentration of great authority in the Minister of Health. At its best, such a plan could make for efficiency and the more even distribution of available medical resources to the entire population; at its worst, it could lead to arbitrary decision, stifling of individual initiative, and dictatorship. The over-all control of Parliament, with the increasingly complex domestic and foreign matters with which it will have to deal, will necessarily become more and more general and therefore less effective in checking detailed abuse; only matters likely to become party issues can be assured of close examination and careful study of all the factors involved. Under such circumstances, it would seem advisable that every practicable democratic control should be employed in a scheme like the National Health Service, which admittedly requires central control for efficiency but which also opens the way for possible administrative abuse. Such controls might include more democratic methods of appointment of administrative officials under the scheme and such devices as public hearings on major regulations and orders of the Minister of Health or before reconstitution of important administrative bodies.

The absence of direct democratic control over the important hospital and specialist services in the new scheme is one indication of a possible need for a change in local government structure. At present, local public hospitals are subject to fairly direct control of the local electorate through the county and county borough councils; under the new organization, no one will vote for or against members of a regional body, since that unit is not provided for in the local governmental system. The remedy probably lies in a reform of local government rather than in a change in the health program, since this is a problem that is not peculiar to the health scheme alone. Technical, functional, and economic considerations for using administrative areas larger than the traditional county will undoubtedly assume increasing importance as the national government takes over more and more services and industries.

Thus the experience of the British government in formulating plans for a free, comprehensive, and universal medical-care program serves to illustrate some of the inherent and basic difficulties which such a program poses to a democratically oriented nation. Remuneration of the general practitioners by capitation fees plus some element of basic salary; a centrally administered system of "negative control" over the geographic distribution of general practitioners; the transfer of all hospitals, both public and voluntary, to the Minister of Health and their reorganization on a regional rather than a county basis; and a highly centralized administration of the entire program are the answers given by the present Labour Government to the main problems that arose in planning the new British service. The launching of the National Health Service program in 1948 and the experiences of Great Britain in putting the plan into operation and in meeting the many obstacles that will undoubtedly be encountered before the new scheme is running smoothly will be of exciting interest to every country in the world eager to advance the social security of its people.

COMMUNITY SERVICE SOCIETY
NEW YORK CITY

FINANCING PUBLIC ASSISTANCE AND SOCIAL INSURANCE. I

MARY SYDNEY BRANCH

PUBLIC welfare programs cannot be intelligently considered apart from the taxes used to finance them. While social workers are not responsible for the use of regressive taxes for supporting the two major income-maintenance programs of public assistance and social insurance, they cannot ignore the implications of such taxes. Taxes bearing heavily on the low-income group do not constitute a sound basis for welfare financing, since they further reduce the income of those whose poverty the revenues are used to alleviate.

Since the depression of the thirties and the passage of the Social Security Act in 1935, billions of dollars of public funds have been spent for welfare every year. The manner in which these funds are raised is of basic importance to social workers. The net balance of social gain from any welfare program is dependent upon the manner used to finance it. Furthermore, now that public welfare has become a major government expenditure, its financing may have repercussions upon the whole economy, since there is a close connection between government fiscal policy and general welfare. Public welfare administrators, in particular, need to understand the financing of the programs they administer since they may exercise considerable influence in securing funds, their programs must often compete with other government programs for funds, and frequently they must answer the protesting taxpayers and voters who believe that too much money is spent for public welfare. All social workers—case workers, group workers, administrators, supervisors, and consultants—whether they work in government or in voluntary social agencies, should be intelligent about public welfare programs, should understand their financing, and should be active in promoting a sounder financial base for public welfare. A consideration of the financing of the two social security programs of public assistance and social insurance will serve to illustrate principles applicable to all public welfare programs.

FINANCING PUBLIC ASSISTANCE

The Social Security Act of 1935 provided federal funds to assist in financing state programs of old age assistance, aid to dependent children, and aid to the blind. The funds were provided up to a maximum amount with the requirement that the state must assume some financial responsibility as a condition for the receipt of federal money. In some states the nonfederal share of the public assistance grants is borne entirely by the state governments; in other states it is shared by the state and local governments. No federal money was provided for the general assistance programs which are financed throughout the country entirely from state and/or local funds.

The 1939 amendments to the Social Security Act changed the federal matching maximums for individual payments to recipients. The amount of assistance shared by the federal government with the state was limited to a federal-state total of $40 a month for a recipient of old age assistance or aid to the blind and $18 for the first child and $12 for each other child aided, in a family receiving aid to dependent children. Federal funds could

represent no more than $20 a month of the payment to an aged or blind person; and, to families receiving aid to dependent children, $9 a month for one child and $6 additional for each other child aided. States may make payments in excess of the federal maximums; but, if they do so, they must pay the additional amounts from state or local funds.

In 1946 the federal matching maximums were modified somewhat by Congress. They were increased from $40 to $45 a month for old age assistance and aid to the blind; from $18 for one child and $12 for each additional child aided to $24 and $15 for aid to dependent children. Furthermore, the federal share of assistance payments was increased under a formula permitting the federal government to pay two-thirds of the first $15 of the average state monthly assistance payment for the aged and the blind and of the first $9 for dependent children plus one-half the remainder of such average payments. These amendments became effective October 1, 1946, and were to expire December 31, 1947. Public Law No. 379, extending the provisions of these amendments for additional federal aid until June 30, 1950, was recently enacted by Congress.

The provision of federal grants to the states for the categorical assistance programs was an effective instrument for bridging the gap between the fiscal and administrative capacity of the states. It provided an element of flexibility in an otherwise rigid constitutional system. Grants by Congress rest upon its power to spend for the general welfare, but the grants make possible indirect controls in a field in which question might have existed about the power of Congress to control directly. In the absence of federal grants for public assistance, one of several alternatives would have been necessary. Either the public assistance programs would have been left without adequate support, or states and localities would have extended their tax systems to include taxes ill adapted to them, or the federal government would have been required to take over the administration and financing of the assistance programs.[1]

Federal matching grants.—While the provision of federal funds has made available more money for the categorical assistance programs and made possible the establishment of national standards and the exercise of federal supervision over the state-administered assistance programs, the matching grants have resulted in serious disparities in the size of the average grants to recipients in different states. The poor states, unable to appropriate so much money for assistance, have received less from the federal government, while the wealthy states have been able, although not always willing, to take full advantage of the federal money available up to the maximum. Even though some states have exceeded the maximums by providing for grants to recipients over and above the amount matched by the federal government, in other states the maximums set in the federal law have tended to restrict the size of grants to recipients. In 1945 twenty-five states for old age assistance and aid to the blind and sixteen for aid to dependent children limited all payments by law or practice to the amount which the federal government will share equally.[2] Among the states that have retained maximums in the state public assistance laws, federal

[1] Alvin Hansen and Harvey Perloff, *State and Local Finance in the National Economy* (New York: W. W. Norton & Co., 1944), pp. 122–24.

[2] *Annual Report, Federal Security Agency, 1945*, Sec. V, p. 69.

ceilings remained the most common state maximums in 1945. They applied to all recipients of old age assistance in eighteen states, of aid to the blind in twenty-three states, and of aid to dependent children in fourteen states.[3] The laws of some states, limiting payments to the federal ceilings, have set maximums in terms of whatever amount is established by the federal act. Some states, with no legal maximums, limit payments by administrative action to the amount subject to federal matching.

In states which limit payments to the federal matching provisions, some needy persons receive no care or inadequate care. The records of assistance agencies throughout the country show that many recipients need payments larger than the maximum amounts subject to federal matching.[4] And, because of limited state and local funds in some states, assistance payments are restricted far below need, even though higher payments would be matchable.

Some states have set state maximums above the federal maximum for one or more assistance programs, some have provided for higher payments for recipients with special needs, while others have removed maximums entirely. By the end of 1945 eight states had maximums above $40 for old age assistance, six states permitted higher payments for recipients with special needs, and twelve states had no maximums. For aid to the blind four states had maximums above $40, four permitted higher payments in special circumstances, and thirteen had no maximums. For aid to dependent children seven states had maximums higher than the federal ceilings, one of these permitted higher payments if the payment included medical costs, and twenty-six states had no maximums.[5] Recently some states have found it necessary to raise the maximums in order to take advantage of the increased federal funds made available by the 1946 amendments.

Because the federal maximums are higher for old age assistance and aid to the blind than for aid to dependent children, a larger proportion of the payments to aged and blind recipients are shared on a fifty-fifty basis by federal funds. In 1945 the federal government met about 47 per cent of the cost of total payments of old age assistance and about 47 per cent of the cost of aid to the blind in states administering programs under the Social Security Act. Because of the greater need for payments above the federal ceilings in aid to dependent children, federal funds met only about 35 per cent of the total aid given to dependent children in 1945.[6]

The system of matching grants has resulted in favoring the wealthy states, since the federal grant for a state's program is governed by the amount the state or the state and its localities provide. If a state puts up a large amount for public assistance, it receives a large federal grant. If its appropriations, through necessity or choice, are small, it receives a small federal grant. Furthermore, if the localities are required to share in the financing of public assistance, as they are in twenty-eight states, the amount the locality puts up determines how much it gets in state and federal funds, and many localities lack the funds to provide for

[3] Committee on Ways and Means, House of Representatives, *Issues in Social Security: A Report by the Committee's Social Security Technical Staff* (1946), p. 279.

[4] *Ibid.*, pp. 276–78.

[5] *Ibid.*, pp. 278–79.

[6] Federal Security Agency, Social Security Administration, *Social Security Yearbook, 1945*, pp. 160–62.

adequate public assistance grants. When there is a legally fixed matching ratio between state and local funds, the extent of federal participation may be limited by the tax yields in the localities. Thus, variations in both the amounts of payments to recipients and in the relative number of recipients exist throughout the country. The variations in average payments to recipients for the three categorical assistance programs are evident from material published frequently by the Social Security Administration.[7] In June, 1946, the average old age assistance payment ranged from $11.79 a month in Kentucky to $53.53 in Washington. For aid to dependent children the range in average payment was from $21.37 per family in Kentucky to $99.28 in Washington. In aid to the blind average payments varied from $13.34 in Kentucky to $59.61 in Washington. Table 1 shows clearly the variation in average payments among the states. In general, of course, payments are small in states in which poverty and need are great. The variation reflects, to some degree, difference in cost of living and in standards of living but grows primarily out of differences in fiscal capacity.

TABLE 1*

DISTRIBUTION OF STATES BY AVERAGE PAYMENT FOR PUBLIC ASSISTANCE PROGRAMS DECEMBER, 1945

Average Payment	Old Age Assistance	Aid to the Blind	Aid to Dependent Children (per Family)	General Assistance (per Case)
Total	51	48	50	46
Less than $10.00	.....	.....	.....	1
$10.00–$19.99	11	7	.....	8
20.00– 29.99	9	10	8	15
30.00– 39.99	27	22	15	15
40.00– 49.99	3	7	.....	7
50.00– 59.99	1	2	7	.....
60.00– 69.99	.....	.....	11	.....
70.00– 79.99	.....	.....	2	.....
80.00– 89.99	.....	.....	6	.....
90.00– 99.99	.....	.....	1	.....

* Federal Security Agency, Social Security Administration, *Social Security Yearbook, 1945*, p. 153.

Interstate comparisons are facilitated if public assistance costs are reduced to a common unit such as expenditures per inhabitant. In the fiscal year ending June, 1945, variations among states in expenditures per inhabitant were large.

TABLE 2*

DISTRIBUTION OF STATES BY PER CAPITA EXPENDITURES FOR FOUR PUBLIC ASSISTANCE PROGRAMS, FISCAL YEAR, 1944–45

Per Capita Expenditures	Number of States
Total	49
$ 1.00–$ 4.99	14
5.00– 7.49	12
7.50– 9.99	14
10.00– 14.99	6
15.00 or more	3

* Federal Security Agency, Social Security Board, "Expenditures per Inhabitant for Public Assistance, 1944–45," *Social Security Bulletin*, IX (January, 1946), 35.

For all programs combined, the range was from $1.59 to $22.20; for old age assistance, from 89 cents to $19.06; for aid to dependent children, from 17 cents to $2.93; for aid to the blind, from 4 cents to 50 cents; and for general assistance, from 2 cents to $1.68. The distribution of states by size of total expenditure per inhabitant is evident from Table 2.

The analysis of the Social Security Board of the causes of this variation emphasizes the difference in relative fiscal capacity of the states. Such wide variations obviously result from factors other than the extent of need.

The diversity in the economic capacities of the States is indicated by their wide differences in per capita income. For the 3 years 1943–45,

[7] See, e.g., *Annual Report, Federal Security Agency, 1946*, Sec. VI, p. 532.

the average income per person ranged among the States from a low of $527 a year to a high of $1,489, while that for the Nation was $1,108. Eight States had per capita incomes of more than $1,300, in contrast to 8 others where per capital income was below $750. In 31 States, per capita income was below the average for the Nation.[8]

Variations from state to state in average grants and in per capita expenditures arise not only because of variations in the extent of need but also in the standards for determining need, in the policy for the use of available state and local resources, and in the capacity of the state to provide its share of the funds to finance the assistance program.

When a state lacks money to meet the requirements of all needy applicants, it may follow one of several courses. It may limit the amount that may be paid to individuals or families by setting a maximum. Or, in computing assistance payments, it may limit consideration to certain requirements only, such as food, shelter, and fuel, eliminating other essentials like clothing, recreation, and medical care. Or the state may reduce the amounts for particular requirements. Or it may decide that no needy person may receive more than a portion, say two-thirds, of the amount needed. Or it may maintain its standards of assistance for those on the assistance rolls and take other needy persons only as cases are closed.[9]

Authorities have criticized the national grant-in-aid system because it comprises a series of unco-ordinated grants with sums which do not represent the relative national interest in the various services to which money is granted.[10] The over-all picture has not been kept in view in allocating federal funds, so that federal aid has resulted in undue emphasis upon some services at the expense of others. This has been particularly noticeable in the welfare field in which the matching grant has diverted local funds into fields for which federal money is available and state and local budgets have been biased in the direction of the aided services. Local budgetary responsibilities are thrown out of balance because poor states in an effort to take advantage of federal aid for certain services exert themselves in these areas, leaving inadequate resources to cover other equally important obligations.[11] Thus, since federal money has gone to old age assistance rather than to general assistance, states have appropriated considerably more money for grants to old age assistance recipients than for recipients of general assistance. There is ample evidence to show that the federal grants for special categories have distorted state budgets, especially in the poorer states, reacting with particular force against state expenditures for general assistance. The majority of low per capita income states have low figures for state and local expenditures for general assistance as a percentage of total state and local money provided for the three special categories plus general assistance. For example, in Mississippi, Tennessee, and Oklahoma general assistance expenditures comprised 3.68 per cent, 6.78 per cent, and 8.06 per cent, respectively, as compared with 77.09 per cent in New

[8] *Annual Report, Federal Security Agency, 1946*, Sec. VI, p. 498.

[9] *Annual Report, Federal Security Agency, 1945*, Sec. V, p. 66.

[10] See, e.g., Hansen and Perloff, *op. cit.*, p. 125.

[11] *Federal, State, and Local Government Fiscal Relations: A Report to the Secretary of the Treasury by a Special Committee To Conduct a Study on Intergovernmental Relations in the United States* (Senate Doc. 69; 78th Cong., 1st sess. [Washington, D.C., 1943]), p. 169.

York, 74.42 per cent in Rhode Island, and 68.86 per cent in Pennsylvania.[12]

A comparison of average assistance payments, by program and state, in recent publications of the Social Security Administration shows clearly that the variation among states is greater in general assistance than in the special categories and that the average general assistance payments are lower.[13] Because of this, the Social Security Board has recommended a fourth category providing federal funds for general assistance.

Hansen and Perloff suggest that federal aid should be extended under broad general-function grants such as education, health, and welfare so that funds may be used for all aspects of the broad service. This would represent a shift from an unbalanced stimulation of a few favored services to the support of several broad categories.[14] However, the proper use of federal funds for all aspects of such a broad function as welfare would probably necessitate strong federal control and supervision of the states.

Whatever steps are taken to adjust this difficulty, it is clear that some change is needed. The federal grant-in-aid system grew in a piecemeal fashion and is in need of rationalization. The preferred position now given to certain government functions is not defensible.

Federal variable grants.—Another much needed change in public assistance financing is the substitution of variable for matching grants to the state. It has become increasingly clear that, if federal aid is to bring about fairly uniform public assistance standards, use must be made of the equalization principle. Considerable experience with this principle has already been accumulated. It has been used, for example, in the allocation of state aid for education to localities. At the federal level, for example, equalization has played a part in the allotment of public health aid and in relief grants under the Federal Emergency Relief Administration.

The Social Security Board has consistently advocated variable grants for public assistance. In its *Fifth Annual Report* it stated:

> Future development of the public assistance programs under the Act in terms of the quantity and quality of assistance and its equitable distribution would be furthered by an arrangement whereby the extent of federal financial participation in the program could be varied to take account of the states' resources and need for assistance. For states with relatively small resources or with relatively great need or with both, the federal grant should represent a higher percentage of expenditure.[15]

Later reports have continued to urge this change.

While matching grants do not recognize differences in the ability of states to finance public assistance or the differences in need because of the greater incidence of poverty in low-income states, variable grants would recognize such differences. However, the many problems involved in the use of differential aids must be recognized.

Equalization grants for public assistance should be based both on the need of each state for public assistance funds and on the ability of the state to meet its own need. These are both difficult to determine; it is difficult to arrive at any measure of need and of ability based upon a defensible measurement of the facts.

Possible bases and formulas for deter-

[12] *Ibid.*, p. 549.

[13] See, e.g., Federal Security Agency, Social Security Administration, *Social Security Yearbook, 1945*, p. 151.

[14] Hansen and Perloff, *op. cit.*, pp. 128–29.

[15] *Fifth Annual Report of the Social Security Board, 1940* (Washington, D.C., 1940), p. 118.

mining variable ratio grants to states have been the subject of continued study by the Social Security Board and of interest to other groups which have advocated differential grants for public assistance.

Recognition of and concern about the variations among states in the levels of payments to public assistance recipients led to a study by the Social Security Board of state differences in economic and fiscal capacity. A source book, *Fiscal Capacity of the States*, was issued by the Board in 1940 and subsequently revised. This study was followed by a series of special studies.[16]

Various measures for determining the need of states for public assistance grants and the ability of states to meet their own need have been suggested. For example, the most comprehensive index of a state's need is represented by the size of its population. An index of need for old age assistance in a particular state may be found in the population figures of that state by age groups. This, however, gives no indication of the relative proportion of the aged group in need. Two states with equal numbers of aged and an equal proportion of the total population over sixty-five might differ in the relative proportion of the aged group in need. Another index of need may be the number of cases on the assistance rolls. However, since this varies from state to state with the variation in attitudes and philosophy about assistance as well as the variation in actual need, it is not an accurate measure. The number of recipients merely indicates the number of persons each state considers sufficiently needy to receive assistance within the funds at its disposal. The per capita income of the state may give a rough measure of variation in need on the ground that the state with low per capita income has a large proportion of its population in need and a smaller percentage of its working population able to support the needy. As a rule, the poorer states with a relatively greater number of needy persons have recognized that need. According to the Social Security Technical Staff of the House Committee on Ways and Means:

> One might expect that the states with low average per capita income, having smaller resources, and consequently lower standards for need, would find relatively fewer persons eligible for assistance and that their recipient loads, accordingly, would be lower than in the states with above-average per capita income. Recipient loads for aid to dependent children and old age assistance show, however, that the poorer states have a relatively greater number of needy persons and, as a rule, appear willing to recognize such need. Only 5 of the 18 states with above-average per capita income have old age assistance recipient loads above average, while only 9 of the 31 states with below average per capita income have old age assistance recipient loads below average. A similar situation exists in aid to dependent children.[17]

The measurement of a state's ability to meet its own need is likewise fraught with many difficulties. The ability of a state to meet its need is determined by its fiscal capacity, which is the ability of the state to raise revenue. Fiscal capacity in turn rests in the main on a state's economic capacity, which is the ability of the state's population, with its available resources, to produce goods and services for the satisfaction of its needs. However,

[16] Issued by the Bureau of Research and Statistics of the Social Security Board: V. O. Key, *The Matching Requirement in Federal Grant Legislation in Relation to Variations in State Fiscal Capacity* (Bureau Memo. 46 [Washington, D.C., 1943]); Paul Studenski, *Measurement of Variations in State Economic and Fiscal Capacity* (Bureau Memo. 50 [1943]); Paul H. Wueller, *Elements of a Variable Grant Formula* (Bureau Memo. 54 [1943]); J. W. Sundelson and S. J. Mushkin, *The Measurement of State and Local Tax Effort* (Bureau Memo. 58 [1944]).

[17] *Issues in Social Security*, p. 290.

a state with high economic capacity might not have high fiscal ability because of the failure of its tax system to tap its economic resources. The best single measure of the economic ability of a state to meet its assistance costs is per capita income. Since assistance costs must be met from tax yields, the state whose tax system fails to correlate with income may not actually have tax receipts corresponding to its economic position as determined by its per capita income. On the other hand, the use of actual tax yields as a measure of ability gives an unfair advantage to the state whose poorly designed or inefficient tax system fails to tap its resources.

Many attempts have been made to measure relative state fiscal capacity.[18] The methods of measurement developed during the twenties and thirties were, first, those based upon estimates of the yields of a model state and local tax system in each state,[19] and, second, those based on a variety of economic and financial items supposed to reflect the taxable income and wealth within each state. The first method required a considerable amount of arbitrary judgment as to what constituted a model tax system and its probable yield in each state. It involved not only an estimate of tax yields based upon unreliable statistical data, but called for elaborate computations, involving possible error. It was subjective, cumbersome, and overelaborate. The second method, involving the use, in combination, of various statistical series, was handicapped, first, by a lack of reliable data on some of the economic and financial items considered indicative of state differences in taxable resources; second, by its complexity; and, third, by the arbitrary decisions required in the selection of weights accorded to the various factors selected for the index. An outstanding example of this type of index was developed by the Municipal Finance Section of the Federal Emergency Relief Administration during 1933–35 in connection with the distribution of federal relief appropriations among the states.[20] The Finance Section set up four indexes as a basis for a formula to be used to measure the respective ability of states to contribute to relief. The first of these was based on ten or more factors believed to have a direct relation to fiscal capacity: state income paid out, value of manufacturing, mining, and agricultural output, wholesale and retail sales, taxable wealth, savings deposits, automobile registration, federal income tax receipts, number of gainfully employed workers, state and local expenditures, revenues, debts, and property assessments. Different weights were assigned to each item. The second series used a large number of modifying factors such as the value of crops, extent of the drought, tax delinquency, number of automobiles purchased, per cent of urban population, and per cent of population on relief. A third index was based on the estimated yield of a uniform hypothetical tax system. These three indexes were merged into a fourth index of fiscal ability with further adjustments for such factors as state constitutional limitations

[18] For a summary and evaluation of these attempts see Studenski, *op. cit.*

[19] See, e.g., Mabel Newcomer, "An Index of the Taxpaying Ability of State and Local Governments," published as chap. vi of Paul Mort, *Federal Support for Public Education* (New York: Columbia University Press, 1936); and Leslie Chism, *The Economic Ability of the States To Finance Public Schools* (New York: Columbia University Press, 1936).

[20] Studenski, *op. cit.*, pp. 21–23; *Expenditures of Funds of Federal Emergency Relief Administration* (Senate Doc. 56; 74th Cong., 1st sess. [Washington, D.C., 1935]); E. A. Williams, *Federal Aid for Relief* (New York: Columbia University, 1939), pp. 180–228.

on taxation, the nature of existing state revenue systems, the pressure of state and local debt, the extent of municipal defaults, and the public attitude toward relief.

Many of the financial and economic series included in this index were crude and based on unreliable or insufficient data. They were weighted in a somewhat arbitrary manner. Furthermore, if an index of fiscal capacity were incorporated into law, it would have to be much simpler and more objective than this index proved to be. J. R. Blough, who was acting as consultant to the F.E.R.A., favored a simple index combining only two series—aggregate individual incomes taxable under the federal income tax and aggregate full value of taxable wealth as reported by the United States Bureau of the Census.

In actual practice this index developed by the F.E.R.A. was used only as a rough guide in the allocation of federal funds and was laid aside when circumstances seemed to make it desirable. Actually, federal grants made to the states under the F.E.R.A. were not always in direct proportion to need or in inverse proportion to ability. The amount of local contributions and the generosity of federal grants were dependent not only upon need and ability, but upon the pressures exerted by the states, regional variations in relief standards, variations in tax systems, variations in attitudes about the proper allocation of political responsibility, variations in the degree of local independence, and variations in the political importance of the states. The F.E.R.A. experience indicated the difficulty in administering equalization grants satisfactorily and the necessity for a definite formula on which the distribution of funds could be based.

Various indexes, other than that of the F.E.R.A., have been developed on the basis of a selected group of economic and financial data. Since 1936 the Bureau of Research and Statistics of the Social Security Board has been working on methods of devising a system of differential grants-in-aid.[21] Tests have been made of some twenty-five economic series of indexes of economic capacity. Of these, seven were selected as representative: value of farm property per farm, per capita bank deposits, per capita income, number of federal individual income tax returns per 1,000 of the population, per capita retail sales, per capita gross postal receipts, and per capita state and local tax revenue. An examination of the relative merits of several possible combinations of these items has been undertaken: first, an index embracing all seven items; second, an index comprising only two items—per capita income and per capita retail sales; and third, an index comprising only one item—per capita income.

Because of the many difficulties in measuring the need and ability of states, opinions have varied as to the desirability of using a single measure, such as per capital income, or a complicated formula involving many factors affecting need and ability. Some of the distribution formulas in actual use have been very complicated. However, in the late thirties interest began to center around the single item of per capita income as a measure of the economic and fiscal capacity of states. While experimenting with various combinations of economic and financial items, the importance of state per capita income figures among these items became apparent. Furthermore, in 1939 the Department of Commerce initiated publication of an annual series of per capita income figures,

[21] Studenski, *op. cit.*, p. 27.

remedying the lack of official figures. With increased experimentation following 1939, the Social Security Board research staffs have tended to favor per capita income payments as a dependable and simple measure of relative state fiscal capacity.[22]

In its *Eleventh Annual Report* the Social Security Board stated:

> Several methods have been developed by which Federal financial participation may be varied according to State financial ability. Of them, the most satisfactory, in the judgment of the Board, are those which vary the Federal share from 50 to some higher percentage, depending on the State's per capita income, which reflects its relative financial capacity. Thus States with per capita income equal to or above the national average would continue to receive about 50 percent of their expenditures, while States with per capita income below the national average would get relatively more. The Federal matching ratio in a low-income State would be governed by the relation of its per capita income to the average for the Nation.[23]

Proponents of this measure admit that the data are far from perfect. Mr. Studenski says:

> While estimates of per capita income are not perfect, they may be expected to be materially refined as additional data become available and better statistical techniques are developed. These estimates relate to the income received in each state, otherwise called income payments to individuals. They provide a fair basis for comparison of the relative economic capacity of the states and a somewhat less precise basis for comparison of their relative fiscal capacity.[24]

Since, however, it is important to arrive at a measure of ability and need which can be clearly stated in legislation and based on a defensible measurement of facts and which is both simple and objective, the per capita income method has convincing advantages.[25]

The recommendation of differential federal grants to the states for public assistance has raised numerous questions. Some of these have been well stated in a recent study of the Social Security Board on *The Measurement of State and Local Tax Effort.*[26] Are states with relatively meager resources making as much effort to provide welfare programs as are other states? Does the less adequate performance of many of the poorer states result not only from lack of resources but also from unwillingness to assume a proportionate tax load for welfare programs? Will increased federal aid for the poorer states lead to higher levels of assistance and services or will the additional federal funds be used to reduce state taxation or to affect diversion of state revenues to functions other than assistance, leaving the former level of welfare expenditures unchanged?[27]

The fear that federal funds might be substituted for state funds has led to the suggestion that federal aid be granted on the condition that state and local expenditures for specific programs be maintained at the level of some prior period. Other authorities have suggested using some measure of over-all state tax effort as an auxiliary determinant in a variable grant formula.[28] Thus, as a condition for increased federal financial participation, the state would be required to maintain its former relative tax effort. Such a requirement appears undesirable, however, since one of the purposes of a federal grant-in-aid would be to relieve the disproportionate tax effort of some of the

[22] *Ibid.*, p. 30.

[23] *Annual Report, Federal Security Agency, 1946*, Sec. VI, pp. 496–97.

[24] *Op. cit.*, p. 1.

[25] *Federal, State, and Local Government Fiscal Relations*, pp. 172–73.

[26] Sundelson and Mushkin, *op. cit.*

[27] *Ibid.*, p. 2.

[28] Wueller, *op. cit.*, pp. 20–22.

poor states. Because of the many problems in measuring state tax effort, a study by the Social Security Board attempted to assess state differences in tax effort and the feasibility of incorporating a tax-effort index in a variable grant formula.[29]

As indicated, considerable attention has been directed toward the results of matching grants, the desirability of variable grants, and the problems involved in their use. As yet, little emphasis has been placed upon the specific sources of funds used for financing the federal grants or for the state and local shares of public assistance costs.

TABLE 3*

INTERGOVERNMENTAL RESPONSIBILITY FOR FINANCING PUBLIC ASSISTANCE, 1945

Program	Amount (in Thousands)				Percentage Distribution			
	Total	Federal	State	Local	Total	Federal	State	Local
Total	$1,066,311	$427,012	$492,395	$146,904	100	40.0	46.2	13.8
Old age assistance	768,781	359,648	349,807	59,326	100	46.8	45.5	7.7
Aid to dependent children	163,633	56,982	78,068	28,583	100	34.8	47.7	17.5
Aid to the blind	28,786	10,383	15,394	3,009	100	36.1	53.5	10.5
General assistance	105,112	.....	49,125	55,986	100	.....	46.7	53.3

* Federal Security Agency, Social Security Administration, *Social Security Yearbook, 1945*, pp. 160–61.

SOURCE OF FUNDS FOR PUBLIC ASSISTANCE

All three levels of government—federal, state, and local—share responsibility for financing public assistance. In 1945 the federal government contributed 40 per cent of the funds, the state governments 46 per cent, and the local governments 14 per cent.

This percentage varied considerably from state to state and from program to program. Federal funds met 45 per cent or more of the total costs in nineteen states, 40–45 per cent in fifteen states, and less than 40 per cent in the remaining seventeen states. In five states, less than one-third of the total expenditures for public assistance came from federal funds. The size of the federal share for public assistance in a particular state depends primarily upon two factors: the proportion of the total spent for general assistance and for payments above the federal matching maximums, since federal funds are not used for either of these amounts.[30]

In 1945, 47 per cent of the amount expended for old age assistance came from federal funds, while the federal share of expenditures for aid to dependent children was 35 per cent and for aid to the blind, 36 per cent.[31] In general assistance, in which there is no federal aid, 53 per cent of the cost was borne by the localities.[32]

The federal government, because of its broader tax base, its more equitable tax system, and its adherence to more

[29] Sundelson and Mushkin, *op. cit.*

[30] Federal Security Agency, Social Security Administration, *Social Security Yearbook, 1945*, p. 160.

[31] The percentage for aid to the blind was low because the aid to the blind programs in Missouri and Pennsylvania received no federal aid. When the exclusively state-financed programs in Missouri and Pennsylvania are omitted from the total, the federal share is 47 per cent, about the same as for old age assistance.

[32] Federal Security Agency, Social Security Administration, *Social Security Yearbook, 1945*, p. 161.

appropriate fiscal policy, has been able to supply public assistance funds drawn from sounder revenue sources than have state and local governments.

Requisites of sound taxation.—Tax authorities have suggested numerous requisites of a sound tax system. One which most of them agree to be of primary importance is fiscal adequacy. The federal government, because of its broader tax base, is better able to secure adequate tax yields than are states and localities. Some states, because of great economic resources, can without difficulty provide tax adequacy; other poor states, even with the best of tax systems, could not expect to have an adequate tax yield.

Economy in the collection of taxes has long been recognized as desirable, as has certainty in the amount, the time, and the manner of payment. Simplicity in the wording of the tax law and in the administrative process is important. Uncertainty and complexity in a tax system bring in their wake public irritation, resistance, and litigation. Diversity in the number and kinds of taxes, elasticity in tax yield in response to changes in need, and flexibility in tax structure are regarded as essential. Equity and justice have often been proposed as the most important of all characteristics. Mr. Groves has indicated that justice does not mean identity of treatment but impartiality of treatment, that it involves treating people in different circumstances differently and people in the same circumstances alike.[33] Although there are practical limitations on a total and complete application of this principle, it is certainly a goal worthy of attainment. It is generally agreed that the best and most appropriate way of distributing the tax burden among individuals to conform to the criterion of justice is in accordance with the ability-to-pay principle.

Unfortunately, the principles of a well-designed tax system are more widely accepted in theory than in practice, so that the major problem becomes one of implementation.[34] This is especially a problem for state and local governments. The federal tax system meets the requirements of a sound tax system to a greater degree as it relies more heavily upon personal, progressive taxes levied according to ability to pay.

Earmarking taxes for welfare.—The money for public assistance furnished by the federal government has come from general revenues rather than from earmarked funds. This is not always the case with state and local revenues. Earmarking is a term used to designate the assignment by law of the proceeds of special taxes to certain expenditures.[35] This has been practiced for many years by local governments which have designated a fixed mill levy on real estate for relief. With the passage of the Social Security Act, however, the practice of earmarking grew as states were faced with the problem of raising a substantial amount of revenue for assistance. Some states found it necessary to devise new and additional types of taxation for public assistance and used earmarking to insure the availability of funds for the purpose.

The dedication of the revenues from particular taxes to specific government programs disregards the requirements of the program, fails to recognize the equality of claims upon state revenue of equally important public functions, disrupts orderly financial planning, in-

[33] Harold Groves, *Financing Government* (rev. ed.; New York: Henry Holt, 1945), p. 26.

[34] Hansen and Perloff, *op. cit.*, p. 250.

[35] Ewan Clague and Joel Gordon, "Earmarking Tax Funds for Welfare Purposes," *Social Security Bulletin*, III (January, 1940), 10–20.

creases the difficulty of ascertaining the availability of funds, and creates a problem of budgeting and financial control. Since there is no correlation between the yield of a specific tax and the needs of a particular welfare program, earmarking is an unsound practice. It is likely to lead to the uneven development of one government function at the expense of another. Although its stated purpose is to make sure of the availability of funds, it actually may result in limiting the amount of funds instead of providing adequate funds. It not only makes budgetary planning and control exceedingly difficult but it also handicaps public welfare administrators in planning the welfare program since the yield of a specific tax is indefinite and they do not know how much money to count on. For all these reasons then, earmarking cannot be defended; yet it is widely used by state and local governments. And often, regressive taxes, like sales and property taxes, which fall with heavy burden upon the low-income group, are chosen for earmarking.

The income tax.—The federal government is not handicapped by the practice of earmarking but draws upon its general revenues for its public assistance grants, giving greater flexibility to federal assistance funds. In addition, within recent years federal tax revenue has come to a large extent from the income tax, which means that a large percentage of federal funds for public assistance come from the best single tax source. An examination of the criteria of sound taxes would indicate that the income tax is the best single method of obtaining revenue. However, until the period of the second World War the quantitative position of the income tax in the revenue system of the country was in sharp contrast to its theoretical virtues.[36] In 1940 only 20 per cent of the tax revenue of the country came from the income tax, while in 1945, 70 per cent of the total tax collections came from this tax.[37] Since all taxes must be paid from income, a tax which comes directly from income and in relation to its size is desirable. The progressive income tax corresponds more closely than other taxes to the ability of the individual to pay, since it is generally agreed that ability to pay is best measured by income. The income tax is a personal, direct tax. It is ordinarily not shifted from the person upon whom it is levied to others. It lends itself well to the use of progressive tax rates, which make possible conformity to ability to pay.

The income tax suffers from certain disadvantages. Its yield is not stable but fluctuates greatly with changes in economic conditions. Because of the use of progressive rates, a doubling of the national income would cause an increase in income tax revenue of considerably more than double. Conversely, a decline of one-half in the national income would cause a greater than proportional decline in income tax returns. Until recently the income tax has been limited in productivity because of the small percentage of the population upon whom it was levied. With the lowering of income tax exemptions during the war, however, the tax became more universal and productive in yield. During the war other improvements in the income tax were instituted. For many years two of the serious limitations of the income tax had been its complexity and the lag in tax payments. The former weakness created considerable public irritation, inconvenience, and expense; the latter was a handicap both

[36] Groves, *Financing Government* (1939), p. 236.

[37] Tax Institute, "Total Tax Collections in 1945," *Tax Policy*, XIII (February, 1946), 1.

to the government and to the taxpayer. The government began to collect income taxes on a given year's income only after March 15 of the following year, while the taxpayer was forced to pay a tax on last year's income at a time when he perhaps had no income or had a reduced income and thus found tax payment difficult. These two serious weaknesses have been modified by simplifying income tax provisions and methods of tax reporting and by providing for collection at the source from the employer. The federal income tax has always involved enormous labor for the Treasury, but on the whole it has been well administered. And while no income tax law could be simple, the recent improvements in this area have shown the possibilities of reducing undue complexities. One further defect of the income tax is to be found in the loopholes, making possible evasion or avoidance of the tax. For example, income tax payment may be avoided by investing in tax-exempt securities, by reinvesting corporate earnings, or by disposing of property to members of one's family. While some of the loopholes have been closed within recent years, others await attention. However, an income tax law free from loopholes would be difficult to devise.

While the income tax has been used with considerable success by the federal government, it has had less success as a state tax. At present thirty-three of the states levy personal income taxes.[38] Many of the most populous and industrialized states, such as Illinois, Indiana, Michigan, Ohio, Pennsylvania, and New Jersey make no use of personal income taxes. Furthermore, in the states with income taxes, relatively little revenue is secured from this source except in four states. In 1941, 72 per cent of the state individual income tax revenues was collected in the four states of New York, California, Massachusetts, and Wisconsin.[39] The failure to obtain much revenue from state income taxes in other states may be attributed to the fear of interstate competition, the lack of administrative and legal talent, the unproductiveness of farm income for income tax purposes, and the low per capita income of many states. However, the state of Wisconsin, the first state to use a state income tax, has extensive rural areas and only a median per capita income and yet has demonstrated the potential productivity of a state income tax if a broad base is used and if the administration is of high caliber.[40]

One serious drawback to the use of the income tax by state governments is to be found in the legal, constitutional, and judicial barriers to income taxation. In some states the courts have upset the income tax enactments of the legislature; in other states the fear of nullification has prevented even initial enactment of income taxes. If income taxes are to play an important part in state taxation, constitutional barriers must be removed, state income tax administration must be improved, and greater uniformity among states will be needed to overcome the fear of the effect of the income tax upon the migration of wealthy citizens to other states. Furthermore, co-ordination between federal and state governments in the income tax field is essential to prevent undue burdens on taxpayers. This problem of undue tax severity has led to several suggestions. One is that a system of tax credits be used by which state income taxes are deductible in computing the federal tax base and federal income taxes deductible in computing the state tax base; another is that the use of the

[38] Hansen and Perloff, *op. cit.*, p. 264.

[39] *Ibid.*

[40] *Ibid.*, p. 265.

income tax be reserved for the federal government and a portion of the yield returned to the states. The difficulties of administering the income tax at the state level have accounted for support of this method of sharing with the states the yield of a federally collected income tax. Concern over the problems of multiple taxation and of double administration have led to an alternate suggestion that the state governments supplement the federal income tax by imposing supplementary tax rates upon the federal tax rate.

In spite of its many difficulties and limitations, the income tax is the most rational method of collecting revenue. This is especially true for the federal government, which does not encounter so many administrative problems as do the states in the use of an income tax.

Property tax.—Although the property tax has declined in relative importance as greater reliance has been placed upon the income tax, it is still a substantial source of revenue. As late as 1940, the property tax was the single greatest source of revenue, yielding 36 per cent of the total federal, state, and local collections.[41] In 1911 the property tax yielded around 70 per cent of the total. By 1945, although its yield was only 9 per cent of the total, it was second only to the income tax in fiscal importance. As federal revenues decline with a retreat from the exorbitant level of wartime spending, the property tax may become relatively more important than it was in 1945, but it is not likely to regain its former predominance in the fiscal pattern.

The property tax is of great importance for welfare financing since it continues to produce the major part of local revenue as well as to contribute to state revenue in some states. Thus, most of the local funds used for financing general assistance and the categorical assistance programs come from the property tax, and a minor part of the states' share of both general assistance and special assistance comes from this source. In 1941 the property tax supplied over 90 per cent of local tax revenues.[42] Since the property tax is the only tax available to many local governments, it must be used for local welfare support. On the other hand, state governments tend to rely less and less upon this source as the property tax has given way at the state level to other taxes such as retail sales taxes, state income taxes, and motor vehicle taxes. In 1941, there were fifteen states which secured no revenue from this tax.[43]

The general property tax is levied at a uniform rate upon the value of all property. Unlike the income tax, the property tax has serious theoretical weaknesses. Since property is not so good an index of ability to pay as income, the property tax does not distribute the tax burden among individuals upon as equitable a basis as does the income tax. Property is not only faulty as a measure of ability to pay, but it also fails to serve as a good measure of benefits received from government. Also, because the property tax makes use of a proportional tax rate, it falls with heavier burden upon low-income groups.

In practice the property tax has many weaknesses. One serious defect is the escape of intangible property from taxation. Although real estate is relatively easy to discover and list, personal property is less frequently discovered by the assessor or declared by the taxpayer, and intangible personalty, particularly, often escapes completely.

[41] Tax Institute, *op. cit.*, p. 1.

[42] Groves, *op. cit.* (1945), p. 56. [43] *Ibid.*, p. 55.

The extreme inequalities in assessment levels, both in the same tax district and between districts, is another serious weakness of the property tax. Underassessment of property within the same tax district often takes the form of assessing low-valued property at a higher per cent of true value than high-valued property. This may result from favoritism on the part of the assessor; he may favor large property owners because of their standing and influence in the community. Or it may result from incompetence; an assessor may be able to determine the value of a modest $5,000 home, while the $500,000 mansion may be beyond his imagination.

In spite of the fact that a good case may be made for full value assessment of property, competitive undervaluation among assessment districts is common practice.[44] Undervaluation of property complicates the assessment process since full value must be arrived at before undervaluation is determined. Undervaluation introduces two variables in the tax—the tax rate and the assessment level. With full value assessments the tax rate is the only variable. This makes the tax easier for the taxpayer to understand and to control. Another objection to undervaluation is the fictitious picture of the wealth of the state given by property tax assessments. This may be especially serious if assessments are used as an index of comparative wealth for practical purposes such as the distribution of variable state or federal grants-in-aid to localities.

[44] Unequal assessment levels among districts are not so likely to occur in states in which the state government derives no revenue from the property tax, since there is not the same incentive toward competitive undervaluation as a way to decrease the proportion of the state's total property collections paid by the locality, which is normally based upon the relative assessed value of property in the localities.

The crux of the difficulty in property tax administration is to be found in the provision for local assessment. The property tax is administered by the localities. The tax administrative unit may be a county, or it may be even smaller—a city, village, township, or school district. The assessors are local officials, who, in most states, are elected. In a few states they are appointed, usually by the county boards. Assessors are usually untrained and unfit for their highly technical jobs. If elected, they may be creatures of a political machine and labor under the handicap of having to curry favor with the voters in order to obtain re-election. The appointed assessor may also be a politician whose appointment may be a political gift as a reward for party regularity. He, too, may be singularly unprepared for his job. Assessors are usually poorly paid and serve for short terms of one to four years. In small jurisdictions, like townships or school districts, they are part-time officials.

Assessed values often bear little recognizable relation to the true value of property. Appraisals of property may be farcical. The assessor may merely copy down the tax rolls of his predecessor, high-valued property may be omitted year after year, glaring inequities and discrimination may continue without correction.

Recognition of the impracticality of the local assessment of railroads and of public service enterprises has led to central assessment of such property. Many industrial corporations, however, have property which in its complexity and difficulty of assessment rivals that of the public corporations. Furthermore, units of large corporations may be scattered over several assessment districts. Yet the assessment of such prop-

erty, even though quite beyond the capacities of local assessors, usually remains within their province.

Various reforms of the property tax have been suggested and in some jurisdictions adopted. If the assessment function were taken over by the state with assessors chosen through competitive merit system examinations, great improvement might be achieved. Short of this, close co-operation with and practical assistance to local assessors by the state tax commission or department of finance would be helpful. Wisconsin was the first state to try this, and the plan was so useful in improving assessments that other states followed suit. In Wisconsin the state was divided into districts in which state supervisors, appointed by and responsible to the state tax commission, worked closely with the local assessors, conferring, advising, assisting, and supervising.

A growing number of assessors' offices are making a technical approach to their function. Buildings and land are assessed separately, sales data are used to check values, technical aids such as property record cards, accurate tax maps, building classification and cost schedules, and mechanical addressing equipment are used. In some states manuals for the guidance of assessors have been prepared, giving a comprehensive and instructive description of types of property and assessment methods. Periodic training programs for local assessors have been tried with success. A functional, rather than merely a geographical, basis for the division of labor among personnel has been useful in making some assessors experts in personal property assessment, others in real estate.

Assessment procedure in cities has usually been more scientific than in rural areas. An increasing recognition of the need for trained personnel has led to the employment of better assessors. Recorded sales, mortgage information, and rental values have been used to determine assessed values and to check against established values. Buildings have been classified into single dwellings, two-family residences, apartment houses, office buildings, stores, and factories; and standard assessment record cards have been kept for the various classes. Records have been kept up to date by frequent reference to permits, sales records, mortgages, foreclosures, leases, and court appraisals. Consideration of such factors as floor space, type of construction, age, obsolescence, and condition of repair has helped to make the assessments realistic.

Efforts have also been made in some jurisdictions to improve the listing of personal property by taxpayers. The average taxpayer reports only the items known to the assessor or easily discovered. The assessor may place a presumptive value upon personal property based upon such factors as the kind of neighborhood and nature of dwelling. In general, personal property is easier to value than real estate once it is discovered. However, one of the obstacles to effective personal property assessment is the fact that personal property has many forms and uses. A technique effective for one type may be useless for others. The more extensive use of public records, such as income tax returns, helps in disclosing personal property. Innumberable other records, such as of bequests, of collateral security for loans, of brokers transactions, would provide additional sources of information about personal property. The taxation of personalty normally exhibits all the worst defects of the property tax—nonassess-

ment, undervaluation, and regression. Some states, like New York, exempt all personal property from taxation. Other states exempt intangibles. Still others tax intangibles at lower rates or exempt a minimum amount of personalty. Some states tax only a small selected list of types of personal property, such as automobiles, cash, and property giving evidence of wealth such as oriental rugs, original paintings, and antiques.

The property tax suffers not only from the difficulties of assessment of property but from poor collection laws and procedures. Many jurisdictions lack sound tax-collection laws, while in others poor tax collections are the result of the failure of local officials to enforce the laws and to use business-like collection methods. In spite of legal handicaps, some officials have obtained good results by placing bills in the hands of taxpayers well in advance of due dates, by follow-up of delinquent taxpayers, by the maintenance of efficient billing, recording, and accounting systems, by interviews with persons delinquent in payments, and by efforts at taxpayer education.[45]

The productiveness of the property tax may be seriously limited by declining property values and by legal handicaps such as tax-rate limitations or tax exemptions. During the depression of the thirties, declining real estate values offered serious problems to local governments forced to rely solely or largely upon property tax for support. Since property values are a function of many, complex factors, this problem is not easily solved. Property values are related to the rate of urban growth, the degree of decentralization, deterioration of physical structures, maladjustment in land use, and the general level of economic activity. Thus, a trend in declining property values might be arrested or reversed by such policies as wise land-use planning and redevelopment programs.

Tax-rate limitations have served to limit the productiveness of the property tax in some jurisdictions. Limits on the rates of taxation that may be levied on property by local governments have been a favorite device by which states have endeavored to control local expenditures. Such rate limitations may be constitutional or statutory and may be limits upon local tax rates for specific purposes or state-wide over-all restrictions on the aggregate rate applicable to property. Such limits may result in extreme rigidity and inflexibility in the property tax and thus may lead to attempts to circumvent the limitation. Where limits operate restrictively, local indebtedness may be increased, and this may mean that local governments borrow for purposes for which borrowing is not justifiable. Or, to evade the rate limit, local governments may resort to the use of substitute taxes or special assessments. In some states certain government functions have been transferred from the government unit subject to the rate limitation to another unit with greater tax powers. For example, one reason for the transfer of responsibility for relief from the counties to the townships in Illinois in 1936 was the constitutional county tax-rate limitation, which seriously limited the county's tax power. Tax-rate limits may also lead to the multiplication of government units. This may be the motivating force behind the creation of such special districts as drainage or sanitary districts. Since the proceeds of the property tax are the product of the tax rate and the assessed valuation, a restricted tax rate

[45] Frederick L. Bird, "Relation of Tax Collection Methods to Delinquency," in *Property Taxes* (New York: Tax Policy League, 1940), pp. 256–57.

may be circumvented by increasing the assessment either by adding new personalty or realty or by raising the ratio of assessed to real value.

In most cases of tax-rate limits it is possible to exceed the limit by vote of the electors in the local unit, or the restrictive effect may be relaxed by authorization of new and additional levies for emergency purposes. Such procedures may be unduly delayed or may involve considerable effort and expense.

In conclusion, tax-rate limits are arbitrary, inflexible, and negative. They often lead to undesirable substitutes for the property tax or to attempts to evade the limitation by unsound methods, such as the creation of new government units or the transfer of government functions from one unit of government to another.

Tax exemption often results in serious limitation of the yield of the property tax, as well as inequitable tax burdens upon individuals. A locality with a large amount of exempt property may experience considerable difficulty in raising adequate revenue from the property tax or may do so only by imposing heavy burdens upon the nonexempt property.

Real estate tax exemptions have increased markedly in recent decades, although the exact amount of exempt property is difficult to determine, since in thirty-two states no effort is made to assess exempt real estate. And in states which assess exempt property, the assessment is likely to be made with less care than that of nonexempt property.[46]

It has been estimated that about $25 billion dollars of real estate is exempt, representing one-sixth or over of the real estate values and one-fourth of the real estate acreage. About two-thirds of the exempt property is governmentally owned, about one-half is state and local, and about one-sixth is federal.[47] Exemptions to religious, educational, and charitable organizations comprise the bulk of private exemptions.

The largest block of exempt property is owned by city governments, and this exemption will undoubtedly continue, as cities will not pay taxes upon their own property. While the existence of intergovernmental exemption has long been a source of irritation and confusion, the situation became even more serious after the initiation of the war-production program in 1941 because of the growth in governmentally owned property. Federal real estate holdings, which had been large before the war, became considerably larger. By judicial interpretation of the federal Constitution state and local governments may not tax the property of the federal government unless authorized to do so. However, the situation with respect to federal property will become less acute because of several developments. First, much war-acquired property has been or will be relinquished. Second, states are adopting laws authorizing the taxation of all federal property which the federal government permits to be taxed. Third, the practice of making payments in lieu of taxes, inaugurated in 1936 with respect to resettlement and slum-clearance projects, has been firmly established and will be more widely adopted. Unfortunately, no development comparable to the in lieu payment has taken place with respect to property within a municipality owned by state or local governments.

The exemption of educational, charitable, and religious institutions has been defended on the ground that such agen-

[46] Tax Institute, "Trends in Real Estate Tax Exemption," *Tax Policy*, XII (December, 1945), 1.

[47] *Ibid.*

cies perform services of value and earn no profit. However, some of them are wealthy institutions and represent taxpaying ability. Furthermore, they may constitute a big percentage of the property of small taxing districts. Abuses of this exemption have included the liberal interpretation of charitable or benevolent to include such agencies as lodges and the exemption of property owned by educational, religious, or charitable institutions but used for business purposes. Criticisms of the exemption of educational, religious, and charitable institutions have been made for generations with little effect. Perhaps the most that can be expected in changing this exemption is its limitation to real estate utilized only for the purposes specified.

Another type of property-tax exemption is the homestead exemption. A wave of homestead exemptions occurred in the thirties, when in a five-year period between 1933 and 1938, thirteen states adopted them. This exemption represents a subsidy to home-owners at the expense of renters and like many other exemptions cannot be defended on logical grounds.

Mr. Groves has pointed out that exemptions should be reasonable and should rest on significant distinctions.[48] Although some exemptions are warranted, an examination of most property-tax exemptions reveals no such significant distinction between exempt and nonexempt property.

This brief account of some of the major defects of the property tax indicates both the need for, and the possibilities of, reform. In summary, helpful changes could be achieved in property-tax administration by giving the assessment function to the state, with assessors chosen through civil service. Short of this, the state tax commission or its equivalent could supervise local assessors. A state could be divided into supervisorial districts with supervisors appointed by, and responsible to, the state tax commission to confer with, advise, assist, and supervise the local assessors. Manuals of a comprehensive and instructive nature can be very effective, as can periodic training programs for local assessors. The authority of assessors should be commensurate with their responsibilities. Some assessors have been handicapped because of a lack of authority. For example, assessment of bank deposits may be required, yet the assessor may not be given the authority to demand a list of depositors from the bank.

Assessments may also be improved by the use of good equipment, such as accurate tax maps, property records, card files, and mechanical addressing equipment.

Review of individual assessments by local boards of review and equalization of assessment levels among counties by state boards have both served to correct some of the worst inequalities of the property tax. Review and equalization procedure are in great need of improvement. Occasionally, a complete reassessment has been necessary to correct gross inequalities, but, because of its costliness and inconvenience, reassessment should be avoided if at all possible and attention focused on improving the quality of the original assessment.

The classified property tax involving a classification of property for taxation at different rates has been suggested as a substitute for the general property tax to diminish tax evasion, promote more equitable assessment, and provide more revenue. Most states using classification have merely applied lower rates to intangible property. A few states have used

[48] Groves, *op. cit.* (1945), p. 434.

more complete classification systems. Classification in some states is impossible because of the uniformity clause in their constitutions.

Since local governments must rely largely or solely upon the property tax for revenue, every effort should be made to improve its administration and correct its glaring defects. However, since property-tax reform comes slowly, most local money will continue to come from a tax which is faulty both in theory and in many of its administrative aspects.

Sales taxes.—Sales taxes, unlike the taxes previously discussed, vary with expenditures rather than with income or the value of property. They may be specific, levied upon one product, such as liquor, gasoline, or tobacco; or they may be general, levied upon the sales of many commodities, as is the retail sales tax. In 1945 selective sales taxes on alcohol, gasoline, and tobacco ranked third in fiscal importance among all taxes, while general sales taxes ranked fourth. The tax on alcoholic beverages yielded 5.24 per cent of the total tax collections of the country in 1945, gasoline 2.34 per cent, tobacco 2.10 per cent, and general sales 1.64 per cent.[49]

Both federal and state governments use the three selective sales taxes—liquor, gasoline, and tobacco. These taxes are defended because of their high productivity, their relative administrative ease, and the fact that they fall upon commodities which are not necessities. The second and third of these defenses need qualification. The federal tobacco tax, which is collected from the manufacturer, is rather easily administered; on the other hand, the state tobacco tax, collected from wholesalers and retailers, is a much more difficult tax to administer. Even though it may be argued that the tobacco tax is fair, since tobacco is not a necessity, the inelastic demand for tobacco means that in actual practice, since the demand for tobacco changes very little with changes in price, the tobacco tax becomes a very effective means of draining government revenues from the bottom of the income scale.

Retail sales taxes are important for welfare financing in many states. In some states they are earmarked for welfare, in others they produce a substantial portion of general state revenue which is drawn upon for welfare financing. Retail sales taxes are usually a lucrative source of revenue, but they, even more than specific sales taxes, are defective because of their regressive effect, falling with heavy burden upon individuals and families with low incomes. While administrative simplicity has often been claimed for general sales taxes, actually the retail sales tax is difficult to administer because of the necessity of collecting it from many retailers. Commodity tax administration is always facilitated if the tax can be levied at a stage in the manufacturing or distributive process where transactions are concentrated in a few hands. The retail sales tax, contrary to this, imposes the tax liability at a point at which transactions are widely diffused. If a commodity is regularly sold in packages, collection is facilitated through the use of stamps, but this is impracticable for general sales taxes. Since retail sales taxes are collected in small amounts from many taxpayers, evasion is often possible.

Particularly baffling administrative problems involve the taxation of small purchases upon which a one-cent tax would amount to considerably more than the tax rate (1, 2, or 3 per cent of the purchase price) and the use of interstate

[49] Tax Institute, "Total Tax Collections in 1945," *Tax Policy*, XIII (February, 1946), 2.

purchases to circumvent the sales tax, since interstate purchases are not taxable. The use of tax tokens or of a schedule of purchases with those under a certain amount exempt from taxation have served to meet partially the first of these difficulties. A use tax has been tried, with varying degrees of success, to meet the second.

Sales taxes are in most cases paid by consumers. Though levied upon the merchant, the tax is ordinarily shifted to the consumer. Occasionally the tax will be absorbed by the person upon whom it is levied. For example, a merchant at a state line, in competing with merchants in a state without a similar tax, may absorb the tax. Since, however, the tax is ordinarily shifted, it is highly regressive, as there is no logical relationship between the incidence of the tax and the ability of the individual to bear the burden.

Every decade, whether characterized by war or peace, boom or depression, inflation or deflation, has witnessed a vigorous movement for a federal retail sales tax. The movement thus far has been defeated by the opponents of sales taxes. However, the sales tax has enjoyed considerable popularity at the state level. Adopted primarily during the depression of the thirties by states as an emergency measure, the retail sales tax has become firmly imbedded in the fiscal pattern of many states. Some few states, once having adopted a retail sales tax, have abandoned it, but, in general, the tax has remained a lucrative part of the state's revenue system. On the other hand, some states have never had a general sales tax. For the states as a whole, sales taxes constitute an important source of revenue, but, for individual states, the sales tax may be of negligible or of no importance.

(*To be continued*)

UNIVERSITY OF CHICAGO

CASE-WORK SERVICE IN DAY-NURSERY INTAKE

HILDE LANDENBERGER HOCHWALD

THE closing of wartime day-care centers has concentrated demand for day care at moderate cost with the few day nurseries which are subsidized by community funds. As a result, there is heavy competition for available vacancies so that not all applicants can be accepted for service. Under these circumstances family agencies participating in day-nursery intake have to make a special contribution. Their experience in allocating scarce resources where they are most needed and in helping individuals to make most effective use of them, or to find some other way of handling their problems, can be adapted to meet the particular situations of applicants for day-nursery care.

In the following paper an attempt is made to develop some case-work criteria for the selection and treatment of applicants for day-nursery care. The material that has been used has come from the writer's experience as a case worker in the St. Louis Provident Association, a family agency giving case-work service to three independent day nurseries which are members of the Social Planning Council and the Community Chest. According to its original agreement with the day nurseries, the agency accepted responsibility for the first interview with applicants for day-nursery care and the settlement of their fee on a sliding scale; but in the course of its co-operation with them it broadened its function to include, as requested, case-work consultation with the day-nursery teachers and case-work service to day-nursery clients.

In the selection of applicants for day-nursery care, the case worker has to deal with two different aspects of their situation. She has to explore and determine with the applicant whether day-nursery care is a suitable plan in view of the family situation. This includes evaluation of the plan in terms of its fitness to accomplish the applicant's purpose, in terms of its effects on the various family members involved, and in terms of the child's readiness for the experience of placement.

With limited placement facilities the case worker also has to determine whether the day-nursery plan is needed to serve some purpose essential for the welfare of the applicant and his family and whether some other plan of day care can be substituted for it. In order to decide if the applicant has any alternatives for day-care planning, the case worker must be familiar with other available day-care facilities and aware of their particular advantages or disadvantages in comparison with day-nursery care. She may compare day-nursery care with other plans of group care or with plans of individual day care.

In comparison with group care in the usual commercial nursery school, the day nursery offers the advantages of its moderate and adjustable fee, its longer hours of service, its more adequate staff and program, and the greater amount of individualized attention a child may receive there, especially through the availability of case-work service. It does not offer transportation which is customarily furnished by commercial nursery schools.

In comparison with plans of individual

day care in some independent foster-home or in the child's own home, which leaves with the parents the responsibility for the selection and management of the person in charge of the child's daily care, the day nursery has the characteristic of fitting the child into a well-planned and well-established routine in the management of which the parents do not have any part.

The case worker must appraise the usefulness of available day-care plans in relation to the applicant's needs and capacities. She will wish to use the day nursery as a resource for applicants who have some specific need for day care at moderate cost and which relieves them of the management of their children's daily routine and assures their children of high standards of care and individualized attention.

If the applicant's need for day-nursery service is established, the case worker may give some thought to controlling the time factor involved in the placement plan. If the problem creating the applicant's need for placement can be handled within a limited period or if the day-nursery plan cannot be considered as a long-range solution for his difficulties, the setting of a time limit for the day-nursery plan may be helpful in keeping the applicant focused on the need of working at his difficulties and prepared for his eventual separation from the day nursery.

The selection of applicants for day-nursery care on the basis of some difficulties in their situations which create their specific need for placement implies that a number of them may be in need for case-work service which they may be willing to accept along with the day-nursery plan.

The case worker's participation in setting up this plan often gives her an opening into the client's situation and a chance to define with him some initial focus of treatment which can be broadened according to the client's needs. Moreover, the case worker's access to what happens in the day nursery through direct observation or through consultation with the day-nursery teacher may give her valuable diagnostic data which she may utilize in the treatment process. At the same time applicants whose request for day-nursery care is being rejected either because placement is not suitable for them or because it cannot be made available to them may be faced with problems with which they cannot cope without help, and they may wish to accept case-work service.

Experience seems to show several reasons for the request for day-nursery care, and these reasons may be said to fall within four general categories: (1) mothers feel pressed to earn money for the support of their family, (2) mothers are unavailable for the care of their children due to physical incapacity or absence from home, (3) mothers show resistance toward the care of their children, and (4) mothers find their children in need of the educational experience of day-nursery care. It is important to examine the reasons underlying the client's request for day-nursery care in terms of their significance for his need for placement and his need for case-work service.

1. A need for the mother's earnings is not uncommonly the basis for the request for day-nursery care in families where both parents are living together, but more often the need is found in families where the mother is the only parent in the home. With both parents living together, the mother's income may be needed in addition to the father's to cover current expenses, clear up debts, or afford some improvement in the family's

way of living as, for example, better housing; or it may be needed as a substitute for the father's income to tide the family over some period of his illness, unemployment, or special training.

In situations of this type the day-nursery plan is satisfactory from the point of view of the family, if the mother is able to fill a job in addition to performing her duties at home. But the need for the child's placement can be established only if, without the mother's earnings, the family is facing serious deprivations. Even then the family may be capable of managing some other day-care plan for the child.

Sometimes the family's need for the mother's earnings is temporary, and their purpose possible of accomplishment, within a definite period. In that event a time-limited placement plan for the child is adequate to meet this situation.

With both parents living together, the mother's wish to earn money also may be symptomatic of some instability in the family situation. The mother's income may be the only dependable source of support, and her wish to work is part of her endeavor to keep her husband in the home at the price of relieving him of financial responsibility. On the other hand, her drive for financial independence may be her first step toward extricating herself from an unpleasant marital situation.

In this type of situation the suitability of the day-nursery plan from the point of view of the family must be evaluated in relation to its effect on the marital situation. If the mother's going to work fits in with the solution she chooses, day-nursery care for the child seems indicated in order to give him some security in the day nursery which he is not likely to have in an upset home situation and not sure to find in any other kind of day-care plan.

Moreover, the case worker's function in setting up the nursery plan may give her an opening into treatment of the marital situation. If so, her knowledge of the child's behavior in the day nursery may enable her to gain insight into the child's reactions to the domestic situation, as well as an opportunity to interpret to the client the child's stake in the possible solution of the domestic arrangement.

If the mother is the only parent in the home, her earnings may be needed as the family's only or main source of supply. In that event, the family's only alternate source of income may be public assistance. But if the mother is capable of supporting the family through her own earnings, this may be the preferable plan since it allows the family to maintain the normal pattern of self-support.

Under those circumstances some day-care plan for the child is needed. Day-nursery care often is the only satisfactory plan offering the child the security and attention he should have in compensation for his deprived home situation and to offer the mother the relief and support she needs in her double role as homemaker and wage-earner.

However, case-work service beyond this may be indicated for the mother. In some instances the mother is making a request for day-nursery care when she has already adapted herself to her position as the only parent in the home. But she may need case-work service to resolve her own feelings over the loss of her husband and to be able to help her child in accepting the absence of his father from the home. In other instances the mother is making the request for day-nursery care at the moment when she is finding herself in the midst of a sudden

family crisis, and then she often needs the case worker's emotional support and practical help both with the details of her planning for employment and in the care of the family to the point where she can make effective use of the day nursery.

2. The mother's unavailability for the care of the child is the basis for the request for day-nursery care in situations where the mother is living with the family but is physically incapacitated or in situations where she has separated herself from the family. The mother's physical incapacity may be due to some temporary disability, with or without hospitalization, or due to chronic illness. In either case the mother usually takes responsibility for working out the day-nursery plan.

In the case of the mother's temporary disability—e.g., due to childbirth or an operation—the day-nursery plan may be the best possible arrangement from the point of view of the family. But the effort of adjusting a child to nursery routines for a very short period is not rewarding and therefore should be avoided if the family is able to make any other satisfactory plan. For families without resources of their own, where there are several children or where the mother is in need of some convalescent care after her return to her home, placing an agency housekeeper in the home is often the more expedient, if not the only constructive, solution.

In case of the mother's chronic illness, the day-nursery plan is suitable and needed if it gives the mother sufficient relief to enable her to carry on with the care of her children at home. But if she is too ill to carry her responsibilities in relation to the day-nursery plan, some other plan for the children's care will have to be considered. Whether or not the mother will be able to make use of day-nursery placement is often difficult to diagnose, and, in that event, placement for a limited experimental period may be indicated, after which joint evaluation of the plan by client and case worker may lead either to its continuation or to the working-out of some other plan of child care.

The mother's separation from the family is usually the result of domestic discord and may occur after a sudden family upheaval. After the mother's leaving of the home, the father usually is the person to make request for day-nursery care. At the point of his application he often is in a state of panic and ill prepared to take over additional family responsibilities. Under those circumstances the day nursery is inadequate as a substitute for maternal care. But it may be the only immediately available resource to protect children from serious physical and emotional neglect. Day-nursery placement for a child therefore may be necessary and useful for a limited period for the purpose of giving the father the necessary time to work out more satisfactory arrangements for the care of his family.

In situations of this type the father will probably be in urgent need of case-work help with his family planning. But sometimes he is too disorganized to relate himself to case-work service or to any other kind of planning and does not even give the child sufficient care at home to make his attendance at the day nursery feasible and profitable. Under these circumstances the neglect of the child may reach a point where the situation must be dealt with on a protective level. In that event the case worker's and day-nursery teacher's observations of the child's lack of parental care may be helpful in working out some plan for protective action.

3. The mother's resistance toward the care of the child is the basis for the request for day-nursery care in situations where mothers, in varying degrees and for various reasons, are protesting against the continuous burden of the care of their children.

Some mothers complain about being tied down or worn out with the care of their children but do not show more than some normal measure of strain along with some capacity to give them love and guidance. As a rule, they request partial relief of the care of their children because they are physically exhausted by their children's demands or because they wish to have some time to themselves for their pursuits. Among them are women with heavy household duties, strong vocational or other outside interests, or a great need for social activities.

In situations of this type the mother's part-time relief from the care of her child will be a constructive plan; by giving her some freedom for needs and satisfactions of her own, it will help her to act in a more loving way to the child and to be more tolerant of him while being with him. For this purpose day-nursery care is a satisfactory plan; but often it is not needed since the mother may have the resources and capacity to manage some other part-time plan of child care.

There are other mothers who want to have part-time relief from the care of their children, not only because they find it difficult to be tied down with them, but also because they do not know how to cope with the task of their management. This attitude is quite typical, for instance, of girls who have entered marriage in order to be compensated for earlier restrictions or deprivations but who are not prepared for its responsibilities. With the support of a fairly stable family setting they may be able to sustain love and interest in their children and yet be too immature to give them guidance and training.

In this type of situation the day-nursery plan may be of great value. It offers the child some guidance and training that he is not receiving at home but may carry over to his home situation. It offers the mother the opportunity to learn, through observation of day-nursery routines, some fundamentals about child care. But it also carries the danger of confirming in her a tendency to shift her maternal responsibilities to some other person. In situations of this type case-work service to the mother may be needed to help her exercise and increase her maternal capacities, and her constructive use of the day nursery may depend on her participation in case-work treatment

Treatment cannot always be focused on the mother-child relationship. The mother may feel that her difficulties with her child are only reflections of marital disturbances, in-law trouble, or other family-relationship problems which will define the area of treatment. Sometimes the case worker may feel that employment outside the home will help the mother to acquire self-confidence, self-direction, or self-discipline and that her ability to pay the nursery bill and to provide for other needs of her child out of her own earnings may become a new source of satisfaction and strength in the development of her maternal capacities. In that event the case worker may request her to accept employment as a condition for continuing the day-nursery plan.

Another group of mothers request part-time relief from the care of their children because they find it difficult to bring them up without the normal protection of a husband or family. Among

them are divorced and deserted women or unmarried mothers whose relationships with the fathers of their children have ended in disaster and whose other family ties have been severed or become fraught with hostility. These mothers sometimes are living alone or sometimes are seeking refuge in the home of hostile and restricting relatives.

Their request for day-nursery care usually is on the basis of their need to go to work, but beneath this realistic motivation there may be some emotional need for more complete relinquishment of their maternal responsibilities which they are too guilty to express. Under such circumstances it may be questionable whether mother and child should be encouraged to continue in their current common living arrangements with the help of the day-nursery plan, and case work with the mother may be needed before a decision about the suitability of the day-nursery plan can be reached. But as part of the case-work plan, day-nursery placement of the child for a limited exploratory period sometimes is a useful device. The mother's partial relief from the care of the child may be necessary to enable her to keep commitments in accordance with the case-work plan. Her practical experience with the day-nursery plan may help her to evaluate this type of care in relation to the alternatives of placement or adoption; moreover, the case worker's observation of mother and child in the day nursery may help her to diagnose the quality of their relationship and to make some plan that would best serve their mutual interests.

There are a few mothers who, under the impact of emotional illness, frankly reject their children and request day-nursery care because they cannot bear their presence in the home. In situations of this type the value of the day nursery depends on the interplay of a number of factors, such as the treatability of the mother's illness, the functioning of the family as a unit, and the relationship of the child to the several members of the family group. If it seems indicated to preserve the family unit with the day-nursery plan, a frequent review of the situation is necessary to determine whether the plan is working out in the interest of all family members involved in it.

4. The child's need for the educational experience of day-nursery care is the basis for the request for day-nursery placement in situations where mothers are concerned about the child's not getting some of the normal enjoyments and stimulations in his own home, or in situations where the child exhibits behavior problems with which the mother feels unable to cope.

Mothers may complain that they cannot provide the outer setting conducive to the child's healthy growth, such as play space, outdoor activities, or companionship of other children, and that, due to these limitations, the child is presenting difficulties which create some friction in the home. In situations of this type the day-nursery plan often is the most suitable arrangement, but in the absence of serious behavior disturbances in the child the use of a commercial nursery school may be considered as a possible alternative.

But in some instances mothers are in a state of acute anxiety over some serious behavior of the child which they have tried in vain to correct in their own home. Feeling that they have failed the child but not knowing what they should be doing for him, they request day-nursery care—sometimes on the advice of their doctor—and consider it as their last resort. If the child's behavior symptoms

are serious, the therapeutic potentialities of the day-nursery plan need careful evaluation, and an exploratory period of case work with the family should precede a decision about the suitability of day-nursery placement.

Exploration of the child's history, the etiology of his symptoms, his parents' feelings toward him, and their day-by-day management of him through case-work contacts with the mother and possibly the father of the child may have to be supplemented by some direct study of the child through case-work contacts with him and, as indicated, by a medical, psychological, and psychiatric examination of him.

Sometimes the child, owing to physical, mental, or emotional limitations, will not be capable of adjusting himself to the day nursery, and then the case worker will have the task of helping the parents work out some other plan of treatment for him. But if the child does not show symptoms that seem to preclude the possibility of his adjustment to the day nursery and if part-time separation from his home seems to be a therapeutic factor, he may be accepted for day-nursery care in case the day-nursery teacher is able to give him the individual attention he may need.

After placement, regular consultation between the case worker and the day-nursery teacher is necessary in order to appraise the child's progress and to work out profitable ways of handling him and his parents in the nursery situation.

In case of the child's adjustment to the day nursery, the therapeutic plan is most effective if it also includes regular contacts between the case worker and one or both parents with the goal of helping them in their handling of the child at home so that whatever gains he may make in the day nursery can be consolidated in an improved home situation. But sometimes parents are not ready to accept this help. In that event the case worker and the day-nursery teacher must decide whether the child's attendance at the day nursery with the amount of support of this plan that the parents are willing to offer is of sufficient value to warrant its continuation.

It has been pointed out that, in view of the scarcity of resources, the case worker must be selective in handling the intake of applicants for day-nursery care. But her study of the situation of individual applicants is leading toward the recognition of the manifold needs for day-nursery care. And she will be challenged to interpret those needs to the community to stimulate the establishment of more adequate facilities.

FAMILY AND CHILDREN'S SERVICE
ST. LOUIS, MISSOURI

REVIEW OF A PSYCHIATRIC FIELD-WORK EXPERIENCE IN A MILITARY HOSPITAL

SYLVIA R. JACOBSON

IN A review of the two-semester field-work placement of two social work students in the psychiatric unit of a Red Cross program in a military hospital, a number of thoughts presented themselves for attention. These have been set down here, as it was felt that they might be of interest to workers, supervisors, and executives who, during the war years, may have had relatively little active contact with the military and with case work in such a setting and now find themselves assessing the value of assignments similar to this in considering applicants who were so placed.

It should be noted that the several points brought out here were those which were largely applicable to both of the students and gave evidence, from group and informal discussions with other supervisors, of being problems of general concern in such student placements. Considerations relative to the individual adjustment and progress of each of the two students have been excluded.

SETTING

Following the expressed interest and approval of the commanding officer and subsequent planning between the graduate school of social work concerned and the American Red Cross, two students were assigned to the psychiatric service of closed and open wards in our 3,500-bed naval hospital on the West Coast, which had full and active medical, surgical, orthopedic, psychiatric, and other regular services. The fairly large Red Cross unit of case-work and recreation staff was well established, and emphasis was consistently placed on a closely integrated program which would be flexibly responsive to the changing hospital and military picture.

The students reported on July 17, 1945, following a ten-day series of orientation lectures on American Red Cross organization, policies, and procedures, which had been held at the chapter house in town. They came to the hospital at a time when the field director was on leave and the supervisor was occupied virtually full time in an administrative capacity. The Dependents' Unit, a new 137-bed hospital for the care of accredited dependents of Navy, Marine Corps, and Coast Guard personnel, had opened on the first of the month; and many projects centering around this and the hospital itself, in which the community participated, were in full swing. Around the time of the field director's return in August, the new north wing of the hospital was commissioned, the patient census increased sharply, and four new wards were assigned to the neuropsychiatric service, where patients with a variety of different diagnoses were admitted from overseas, from aboard ships, from other military stations in the district, and from home. Large drafts of men were admitted at intervals as homebound ships reached port, and the neuropsychiatric wards and the hospital generally were occupied at full capacity. Many men were transferred as rapidly as possible to other hospitals to be closer to home, for convalescence, or for specific treatment. Many others were

discharged from service directly from the hospital, and patient turnover was great. A second brig was opened during this period. Later in August the war ended; and philosophy, directives, and procedures altered as readjustments toward demobilization and a peacetime Navy got under way. As application of the point system widened, high-point staff as well as patients were rapidly separated, and the turnover of medical officers at some periods was so extensive that it was literally a case of "here today and gone tomorrow." In the early fall the number of beds allocated to patients of the Veterans Administration was increased, and returned prisoners of war began to be admitted in great numbers. In December, holiday planning and activities occupied a large share of attention. Around the close of the year the intake of neuropsychiatric patients decreased, two wards were withdrawn from this service, and there was an appreciable lessening of the number of patients admitted by reason of operational and combat fatigue. At this time a new chief of service replaced the former one, and many new doctors, interns, nurses, and specialists attached to the hospital corps formed the still changing cadre of a virtually new staff.

This review of the events and changes of the eight months between July, 1945, and March, 1946, has been given here because these constitute the background of this student placement. It has been marked, as shown, by violently changing circumstances, pressures, philosophies, and personnel.

PLACEMENT

Both students were young women who had had considerable previous civilian agency experience and practice, were now in their second year of graduate study, and were eager for psychiatric specialization. Neither, nonetheless, actively desired placement at this station, both because of the great distance between the hospital, the school, and their homes and because of hearsay information of an adverse character regarding the role of Red Cross in naval placements generally. When the placements were arbitrarily made by the school, both students had a good deal of unhappy feeling to overcome. While both tried to accept the situation with reasonably good grace, their acceptance was tinged with reservation. To a certain extent they held onto their feelings of having been ill used in being assigned here and attempted to employ these feelings with the school as a bargaining tool for consideration in the matter of courses and hours. When, therefore, in the course of case-work discussions, feelings of dissatisfaction grounded in actual problems connected with the setting were expressed, they were inevitably infiltrated with the students' own personal rejection of this placement. As long as their frustration contained other positive values for them, repeated attempts to work through their feelings were time-consuming and little productive. In addition, even when they were given incontrovertible evidence of the warm regard in which their unit, their professional services, and they, themselves, were held by the military, they continued at times to question the acceptance of Red Cross by the Navy.

ORIENTATION TO RED CROSS

The preliminary orientation of the students to the Red Cross program appeared to be sound and withstood the test of eight months' practice. Much appeared to have been done during the brief period prior to their arrival here in interpretation of policies and of procedures

and of the organization as a whole. Their use of Red Cross chapters for referrals, for social histories, for co-operative endeavor, was easy and appropriate, and they made similar understanding use of volunteer services when indicated. They represented Red Cross to the naval staff and hospital offices purposefully and efficiently on a variety of occasions, and it was strongly felt that the fact that within the hospital, at least, they were uniformed was of great help in this. This easy, preliminary adjustment was important, because they soon had to acquire a like understanding of naval terms, customs, and procedures and had to learn to work, so to speak, in an agency set both within and beside another while still retaining their own positions of school students.

One question did arise, however, quite early and as our students first went around the wards. They found, with considerable surprise, that to the patients on the wards they were neither social workers nor psychiatric social workers but just "Red Cross girls." This variously meant volunteers, friendly visitors, or recreation workers, according to the previous experience of each patient with Red Cross services. They were met with friendly and casual greetings, with requests of all sorts, for cigarettes, for Ping-pong balls, for directions for getting to town, for the name of a good hotel where a wife might stay, as well as for assistance in an emergency, a loan, or help in understanding medical restrictions. From the springboard of this relationship, begun on their patients' terms, the students had to learn to assess the meaning of the contact and what indications might lie within it for fuller use of themselves as psychiatric social workers. Questions of identification and function were thus early and unexpectedly allied with problems of case-finding and case selection. The working-out of this led promptly and naturally to a recognition of the extent of their responsibility to make it possible for patients helpfully to use, with a psychiatric social worker, a relationship begun on almost any basis with a "Red Cross girl." They quickly came to see that skill in their own ability to identify themselves and their services, whether verbally, by relationship, or through any phase of case-work process, might be considered one of the indices to the possibility of treatment.

Once this hurdle had been jumped, our students readily identified with the interest of Red Cross both in individual patient's situations and in the larger hospital task and threw themselves wholeheartedly into an integrated case-work–recreation program without apparent sense of loss of identity or function.

ORIENTATION TO STAFF AND TO NEURO-PSYCHIATRIC UNIT

At a general staff conference prior to the arrival of our two students, when the anticipated placement was presented for discussion, the plan met with full and keen staff interest. It was decided that the students would not be referred to as students but would be considered as part-time workers of our regular staff and would be fully included in all possible ways. When they came, both girls established themselves promptly and firmly in the neuropsychiatric unit, which then included two psychiatric social workers, two secretaries, and one hospital worker in their own set of offices. They adjusted equally well as part of our total staff, and their co-operative relationships were sound and productive.

The students participated in the weekly meetings of the unit, which included

recreation workers and sometimes guests, and took their turns along with staff in chairing meetings. While it was at first wondered if the inclusion of others would not militate against professional discussion of value, we found that our constant attempts to phrase discussions in nontechnical terms and as simply and directly as possible were helpful to the students and to the regular workers as well, as they redefined for themselves their elementary case-work concepts. The students were invited to participate in regular staff meetings, were held responsible for full Red Cross services to their patients and, later, to their assigned wards, and covered our regular workers on their days off. They were not listed for weekend or night duty. Every effort was made to give their dictation and their conference periods precedence over those of other workers.

The students generally performed so capably that it was repeatedly found necessary to protect them against taking on themselves a variety of duties which would ordinarily have fallen to any available staff worker and which they should not have shouldered because of their classwork and the time that this and its preparation required. Although this had not been our aim, we found that both quantitatively and qualitatively they contributed significantly to an extensive program of social service carried on by Red Cross in this hospital and that they fully earned the warm, spontaneous praise which came to them from the military verbally, in written comments in patients' medical records, and, indirectly, through the increasingly responsible use made of them on the psychiatric service.

ORIENTATION TO THE MILITARY

Shortly after their arrival the students were presented to the chief of the Neuropsychiatric Service, who held an hour's introductory conference with them. At this time he simply, fully, and realistically described to them the function of the Medical Corps of the United States Navy and its relationship to the Navy, of which it is a part. He told them the motto of the Medical Corps, "To keep as many men at as many guns as many days as possible," with some specific and well-drawn examples of what this actually meant when, ashore in a hospital, a naval medical officer considered a patient and the diagnosis, treatment, and disposition to be determined upon. He brought out, in his talk, the several responsibilities recognized by the medical officer to the Navy he served, to the "NP" patient, and to the civilian world to which a great part of the present Navy would undoubtedly return. He further reviewed the kinds of patients who were admitted and the problems their illnesses and disorders presented to the Navy aboard ship and at shore stations, and he discussed the rationale of naval psychiatric diagnoses. He also mentioned something of the varied training, experiences, and philosophies of the psychiatrists then on the staff and what they were and were not attempting in treatment.

While both students, although in different degrees, expressed their acceptance of the military setting, time and practice showed increasingly clearly that there were difficulties interfering with their ability to relate freely to the program.

Outstanding was their difficulty in understanding and accepting the idea that the ward doctors were, first of all, naval medical officers charged with the carrying-out of specific military responsibilities (which, in their case, lay in the sphere of medicine) to the Navy and were, in a sense, secondly "doctors" to their "patients." That considerations of au-

thority and an officer–enlisted-man relationship existed within the latter they recognized only intellectually for some time. They long failed to appreciate, as their patients so fully did, that the ward doctors were also the immediate commanding officers of the men assigned to their wards and, as such, had administrative and military responsibilities over these men in addition to, and inclusive of, their medical ones. These were the very points which had been painstakingly set before them. Our students brought to their relationships with naval medical officers their own civilian associations to the term "doctor," together with that concept of a consulting psychiatrist gained in the psychiatric specialization at school. They tended, at first, to relate to them as though they were doctors attached to, but not part of, the Navy and appeared to anticipate that their patients would so regard them. This became most apparent when they returned frustrated from conferences, and inquiry revealed that their frustration seemed in part to have sprung from a hitherto unvoiced feeling that they could count on the naval medical officer, when once he fully understood a man's situation, to take the latter's part in a struggle against the demands of the service.

Also, while our students promptly recognized the difference in responsibility and authority between the intern temporarily attached to the ward and the regular ward medical officer, they seemed to find it hard to understand and, in fact, appeared openly to resist understanding the relationships among officers of different ranks attached to the same service. This was of importance, as they dealt with patients, both regular Navy and reserve, who referred to their medical officers as "the j.g." or "the three-striper," for example, and who instantly discerned what bearing on the administrative, military, or medical decision regarding their cases their officers' ranks had. Our students noticed with surprised amusement, at first, that, when they asked a newly admitted patient who his ward officer was, he seldom knew his name but could reply at once with his rank, saying, for instance, "It was the Lieutenant Commander who talked with me." The students seemed to pride themselves on holding a concept of democracy which ignored differences in rank, and for some time they openly asserted that the rank of an officer made no difference to them.

Further difficulties were apparent as they worked with patients under disciplinary status in the wards and in the brig. While many of their questions and feelings were undoubtedly sound and derived from sincere, direct, and profound thinking, they represented an inability to accept for their patients the very real military world, defined in the Articles of War, which made up the daily life of the men. The more skilful their own case work in helping men to express their feelings, the more apparent became their inability to relate themselves to the concepts of military authority from which disciplinary situations sprang. They found it hard to accept a system of penalties and punishments, particularly where there appeared to them to be a gross disproportion between the seemingly trivial offense and the severity of the punishment. Our students' understanding lagged far behind that of their patients, and they failed at first to be alert to and to appreciate the extent and basis of certain of the anxieties which their patients were experiencing. They were, indeed, quick to recognize and to identify with the lively hostility against the service which was (apart from other and great considerations) so often a prompt expression of deep anxiety. These attitudes

were particularly noticeable as our students worked with situations involving desertions and courts-martial, where, when they perceived evidences of psychiatric disturbance, they at once assumed that this consideration would take precedence over questions of discipline.

Similarly, the students only slowly showed their understanding of the relationship of the ward medical officer to the chief of service, his to the executive officer, his to the commanding officer, and his, in turn, to the bureau of medicine and surgery. These difficulties were encountered as the students dealt with situations wherein social factors in a man's home and the implied need for his presence on leave or by discharge from the service seemed to them to be self-apparent. In instances where such a need for leave or discharge was fully recognized and recommended by the ward medical officer but later disapproved by higher authorities, our students found it hard to see and to accept the elements which might have weighed against the plan militarily even when these were carefully explained to them by officers responsible for this decision.

In general, they approached questions pertaining to the military nature of problems and to disciplinary status from a civilian point of view, and their frame of reference for long remained the individual rather than the individual within the service. In attempting to work through these problems, analogies were sometimes drawn between the authoritative nature of a military setting and that of a civilian setting such as a court. Here, while they could see that a man might be subject to authority for specific actions, duties, or responsibilities, both students in large measure failed for a considerable period of time to grasp the meaning of the total person subject to military law. They were able, for the most part, to identify promptly and readily with their patients but more slowly with the military; and, as was natural, in their early attempts to relate understandingly to their agency, their patients, and the military, they tended to overidentify with each in turn. Both students early recognized the discomfort that they were experiencing in these conflicts, and they could see the intrusion of these into their practice. They brought up and discussed each situation as it arose with frank thought and feeling and with a readiness to examine patiently into their own attitudes toward authority, toward their concepts of democracy, and, inevitably, toward their placement here.

Related problems arose as the weeks and the cases accumulated. The students complained that their school had not prepared them for this placement by a realistic description of the setting and what they were likely to encounter and, chiefly, that they came expecting to participate in a psychiatrist-psychologist–social-worker team analogous to that obtaining in an established child-guidance agency. They found, instead, a chain of command organization, with its own dynamics within the military relationships. They long clung to the feeling that their school should have better prepared them, despite the explicit information early given them by the chief of the Neuropsychiatric Service and the sustained series of illustrative cases with which they dealt. The students were able to integrate and utilize this information only slowly; and the reasons for this and for their rather prolonged difficulty in accepting their setting, its nature and limitations, are believed to be in part connected with their attitudes toward placement.

ASSIGNMENT OF CASES

It was with several considerations in mind, notably the desire to provide a field-work experience where students would see representative psychiatric problems and participate in appropriate psychiatric social work, that case assignments were at first made individually and on the basis of diagnosis. Primarily, this helped to channel into some related order the tremendous wealth of case material available to them. A very rough preliminary plan grouped the neuropsychiatric diagnoses on the basis of which men were admitted to the service, and assignments were made over the period of two terms in this general order. This was a skeletal guide only and by no means a fixed and rigidly adhered-to plan. While it was quite early found to be a scheme with several values and while the students began spontaneously to relate their classwork, lectures, and readings to discussions around the diagnoses, they did, at the same time, quite naturally begin to carry cases from several groups simultaneously, as admission diagnoses were changed, as patients referred themselves or their "buddies" for help with their problems, and as doctors and nurses requested social-service assistance for individual patients at the moment when the need arose. Our plan, once the first weeks were passed, was often no more than a frame of reference for conference and discussion which brought organization and relatedness to a very great variety of referrals, diagnoses, situations, theories, and cases.

In actual practice both students carried, in the course of the two terms, between twenty-five and twenty-eight cases on the closed and open wards. This number does not include cases assigned to each in which patients consistently failed to keep appointments or were transferred or discharged before they could be seen, nor does it include innumerable brief and largely undictated, although by no means unmeaningful, contacts. Fewer than one-half of the indicated cases represented one or two interviews, about six entailed three or four interviews, while the remainder were carried by the students on a sustained treatment basis and included, in addition to conferences with psychiatrists and other staff officers, planned interviews with families, referrals to recreation, to home service chapters, to the Office of Dependency Benefits, and a host of other resources. Referrals came directly from the men themselves; from medical officers, nurses, and corpsmen; from other military quarters as well as from our own staff of medical and recreation workers; from home service chapters; and, not infrequently, directly from the families of patients.

Admission diagnoses from which assignments were made to students were grouped largely in the following manner. The diagnoses of migraine, gastric neurosis, somnambulism, and traumatic, idiopathic, and Jacksonian epilepsy were assigned first. Many early conferences were focused on the case-work problems around obtaining a social history and the significance of the history in the determination of the diagnosis. Lengthy discussions centered around case-work processes in the situations of patients who, in some instances, had long-standing histories of attacks and, in others, had the term "epileptic" applied to them for the first time.

The diagnoses of mental deficiency, personality disorder, the ineffective individual, schizoid personality, and psychopath were, for our purposes, grouped together. To a large degree, our general conferences, apart from individual case

conferences, centered in the questions of what was treatable and what was not, the importance of discharge preparation for both patient and family, appropriate referrals, and, in all these case-work activities, the significance of a psychiatric approach.

The situational, anxiety, obsessive-compulsive neuroses and the hysteria states were next in order of assignment and provided a multitude of social and case-work problems, which gave rise to eager and increasing query in the areas of treatment, relationship, and techniques by means of which service in each case could be made more effective. Interest was keen; case after case discussed, observed, and followed helped students see that, of the neuroses, *plus ça change, plus c'est la même chose,* and students and workers alike leapt to the challenge of "the psychosomatic approach."

Several cases of the war neuroses, operational fatigue, and combat fatigue were assigned around the same time. Discussions were enriched by the fact that the students together with the staff were invited to attend the series of psychiatric movies shown on the wards and in the auditorium to selected groups of patients as part of an active therapeutic plan.

The reactive depressions, alcoholism, schizophrenia, psychosexual maladjustments, amnesia, and psychoses provided the general group from which the next assignments were made. These gave rise to particularly interesting diagnostic and social case-work material which, the students reported, they were able to use richly in the classroom as illustrative of case-work and psychiatric theories presented there.

Neurological problems, neuritis, paralysis, postencephalitis, and other such diagnoses appearing in the psychiatric wards were used for discussion but not for assignment unless there were other case-work indications of a need for service.

Lastly, as it was strongly felt by the supervisor that a training program in psychiatric social work was incomplete without opportunity for recognition of the problems of mental illness other than those in a designated psychiatric framework and, equally, without opportunity to observe and work with the mental and emotional attitudes of adjustment to illness and injury, a carefully selected, limited group of cases from medical wards was made available to the students. These included patients who had suffered amputations, who had received eye or face wounds, who had malaria, filariasis, ulcers, or hernias.

During the second term a ward was assigned to each student, where she was responsible for providing Red Cross services and where she acted generally in the capacity of ward social worker. This meant building up relationships, as productive as possible, with doctors, nurses, and corpsmen, clearing with the recreation staff around current open- and closed-ward programs and the attitudes and needs of specific patients, being alert to and responding to the need for case work among daily admissions and discharges and in the changing situations of men retained on the wards. The question of ward versus individual case assignments had been a moot one from the beginning, and the plan described was finally decided upon. It represented a somewhat different method from those already familiar to our students and from those under which their fellows were, for the most part, working. Their natural speculations as to its advisability were encouraged. The question was reopened on several occasions, and all the staff, in fact, at times held opinions pro and con.

The students' own final decision was that the method of assignment by diagnosis had been particularly helpful in correlating classwork and field work and in retaining orientation in so extremely rich an experience. They would have been more comfortable in class and wards, however, they felt, had the ward responsibility preceded rather than followed a slowly built-up case load. Riper reflection indicated much to be said for their point of view.

The very great number of patients and the variety of illnesses and disorders, of social situations and problems, that came to this hospital by virtue of its size and location were felt to be of distinct advantage in a learning situation. The close integration of total staff, of medical and recreation workers particularly, and the sustained interest of individual workers of both groups in tuberculosis, cardiac diseases, and other illnesses led to many general discussions around cases outside the immediate activities of students, into which they were, nevertheless, drawn. The students had an experience well representative of the material available, it was felt, as they worked with personnel of the Navy, regular and reserve, Coast Guard, and Marine Corps, both men and women. They dealt with men fresh from boot camp and from domestic stations, men returned from overseas and from prisoner-of-war camps, and they had experience with problems having both psychiatric and disciplinary aspects in both the open and the closed wards and in the brigs. Each student had the experience of working closely with medical officers in continued treatment cases, of obtaining social psychiatric histories both directly from patients and families and through home service chapters, of holding admission and discharge interviews, of interpreting to patients, in accord with medical direction, the meaning of mental illness. They also had opportunity to assist actively in plans for the resumption of civilian life on the part of those discharged and of mobilizing and using all possible resources, military and Red Cross, for critically ill patients or for those confronted by domestic emergencies. The range and extent of treatment at their hands varied, but each had opportunities to recognize that she had performed helpfully in social case-work treatment with patients who had a genuine need for such skilled service and could utilize it to their better adjustment.

SUPERVISORY CONSIDERATIONS

After the problems of orientation and assignment, the supervisory consideration constantly borne in mind, over and above the general placement goals, was to plan so that the students might gain the maximum from this setting's unique features. These were felt to be (1) the tremendous wealth of case material; (2) the great number of short-contact situations; (3) the continued demand for brief, simple services; (4) co-operative work with many different medical officers and other military specialists; (5) opportunity to observe the attitudes of many servicemen at the point of separation from the service and of regaining, with civilian life, the right of independent living.

The first consideration underlay the case-assignment plan and was furthered by the sustained co-operative interest of the military and of our own staff.

Strong emphasis was necessarily thrown on the case-work possibilities of the short-contact situation, the case involving more than one and probably not more than three or four interviews, which constituted a great part of our total case

load. This gave abundant opportunity for inquiry into features conspicuous here: isolating the case-work problem, determining the indications for and against treatment and the function and goals of the worker, and deciding upon effective techniques in the short-contact situation. The students' questions were many, their talks animated. Both expressed the feeling that "treatment" could be accomplished only in sustained cases and that, in the first place, nothing could be accomplished in a few contacts and, in the second, it would be generally unwise to begin "treatment" when the end of the relationship was already in sight.

The students brought open resistance to the idea of consciously undertaking "therapy" in a short-contact situation. When, however, the shortness of time began to be accepted not as an obstacle to effective social case-work treatment but as a framework within which they could examine their responsibility, the areas in which and the ends toward which they might hope to work with effectiveness, they became interested. Through this they began to break down their concept of "therapy" into its component parts and to relate these to what they were daily doing. So simple a step as the referral to a home service chapter they saw not only as part of the case-work plan but as part of the case-work process offering scope for a psychiatric approach. Interest livened, and more attention was soon paid to what could be accomplished in the single interview, especially the interview regularly held with patients at the point of discharge from the service and often our only case-work contact with them. The students' detailed analyses of several of these led them to realize that much more could be accomplished in a single interview than had been apparent to them when operating under the concept that "treatment cases" were naturally of long duration. With increasing security they began consciously to experiment in interviews and to use more nearly to the full, for a case-work approach, the implications to be found in identifying information, diagnosis, the referral itself, and the patient's ability to express his own need for help.

A continued demand for brief, simple services determined the character of much that we did, and the enhanced significance of this was reflected in the students' activities. Because it was strongly felt that this field work represented a case-work experience in a psychiatric placement, constant attention was directed to case-work concepts and techniques and the meaning and use of these with patients in accordance with the evaluations that the students were able to make of each patient's total situation. Our point of reference remained the case-work situation. Discussions around this helped the students to review their elementary case-work concepts, and many of these concepts—such as recognition of the fact that the problem a patient brings to the worker may not necessarily be the only or the greatest problem he is facing or the tendency of an insecure and anxious patient to "test" the worker—they began really to integrate into their practice. They were better able to see a request for a loan or a leave, for example, as part of the patient's total situation and not, as at first, a single request for Red Cross service apart from "case work" or "treatment." Conversely, however, for many reasons peculiar to the military setting, great numbers of patients, brevity of time, urgency of needs, limited individual freedom, and scarcity of opportunity for

recognition of the individual, as well as a host of other complex factors, the simple service, whether the giving of cigarettes or of money or of information, had heightened significance utterly different from its casual counterpart in civilian practice and was charged with emotional attitudes which proved favorable ground for case-work thinking. The students were emotionally aware of this before they found words to explain the unexpected difference which confronted them, and they became more keenly aware both of clues to the need for case work and of the significance of case-work awareness in many necessarily simple, fragmentary, and isolated services.

As the students worked in closed and open wards, caution and close supervision were of utmost importance. These were needed no less as they realized that they were finding their patients generally sharply aware of the shortness and meaningfulness of time, ready to move rapidly, with less resistance and more directness than they had met in early treatment situations in civilian practice. They had to learn, then, to move with them. They began to make use of short cuts which might have been considered contrary to good practice in earlier settings, and not only were they quick to make use of suggestions, but they began to modify these, each in her own way, to meet situations more directly than they had in the past.

It had been felt that the great number of medical officers with widely divergent experiences and philosophies to whom the students had to relate themselves and to interpret their services would provide a challenge not unlike what they might expect to encounter in later civilian practice. At the same time, it was realized that the approach of military psychiatry was vastly different from that presented to students during their schooling and that some orientation on their part would be necessary. While some of our doctors had had previous practices in psychiatry and neurology, most had been in general practice or in other medical specialties. Some found their naval psychiatric training and their present assignment stimulating to a high degree and thoughtfully reviewed many of the cases of their earlier practices in the light of their newer theories. Others speculated freely about the possibility of continuing in this field on returning to civilian life and discussed opportunities for further training. Some of those who were planning to return to their own fields after the war spoke at times of the value of what they were now learning and what they had found, whether theory or technique, which they felt they could adapt to their own uses in civilian practice. Still others regarded the situations in which they found themselves as additional instances of military necessity which could not end quickly enough for their satisfaction and permit them to return to what they preferred. There were some who talked of the "deplorable absence of 'moral fiber' in 'NP patients,'" of their inability "to take it," and were rigid and moralistic in their attitudes. Others tended to see their patients as victims of circumstances, of poor social and economic heritage, completely unprepared and helpless before the grim demands of military life. Varied as were the attitudes, there was common interest in open discussion on all sides of these questions, a strong and consistent readiness to share and to learn from any helpful source new understanding or skills which would be useful.

The students, however, although eagerly following the battledore and shuttlecock of argument, openly and strongly clung to the feelings which they had brought with them to this placement

concerning the philosophy, approach, and personality of a functioning psychiatrist. They expected that he would have analytic background, would be undeviatingly kind, understanding, and fatherly to the men, and would be accepting of social work and of social workers on their terms. A doctor filled their conception of a psychiatrist or he did not; there was no middle ground. When a psychiatrist appeared to them to be something less than perfect in his dealings with a patient, they tended to discard what he did that was of real value. They repeatedly expressed the feeling, in their shocked early days, that it was hopeless to attempt to undertake psychiatric social case-work treatment with patients who were "not getting psychiatric treatment." Their concepts of treatment, too, were limited and rigid. Therapy, to them, was largely analytic, and they showed eager interest in narcosynthesis, in drug and shock therapy, but found it hard to appreciate the very real treatment actually being undertaken on the combat-fatigue wards, through interviews, ward movies, group discussions, and readings in which the concepts of elementary dynamic psychology were related to service experience in the patients' terms. They tended to belittle the significance of treatment of which analytic concepts were not a prominent part.

Out of their hurt and bewildered questioning around these points, their own confusion with regard to relationships between psychiatry and psychiatric social work and between psychiatrist and social worker became apparent. This led, naturally, to group discussions in which the students, together with staff, strove to examine for themselves what both social work and psychiatric social work really meant to them and what its principles really were. Hardly had these been redefined to their satisfaction when there rose the next question, namely, what was the relationship between this "academic thinking," as they termed it, and what they were actually doing daily in their offices and on the wards. The further they moved toward recognizing themselves as practitioners of an independent profession and toward their own conclusions, it was noted, the more anxiety developed. They brought some of these questions back to the classroom and, in turn, brought to the job the enriched thinking they found there. After a difficult middle period, marked by anxious questioning and sharing of thoughts with fellow-students and regular workers, they gained notably in understanding of their profession and, with this, security in its practice. In the instances where they worked, as they had anticipated, in close co-operation with a psychiatrist, they began to do so not in the wholly dependent relationship characteristic of their early weeks but with a sure sense of what they were prepared to provide for patient and for doctor and where this was different from, but complementary to, the doctor's own activities.

With greater freedom in practice, attention was again focused on methods and measures of accomplishing the goals they were now comfortably able to recognize, and two specific areas in which both students acknowledged considerable conflict were reached. Their difficulties again seemed to stem from concepts carried over unmodified from the classroom. Both students made repeated efforts to help men to "talk out" their troubles and appeared to feel that catharsis was a necessary step in virtually any case and one to be employed as early in the relationship as possible. Their success at this,

moreover, seemed to be a test of a good relationship. Only after difficulty and a temporary recurrence of some confusion with regard to their role were they able to see that there might well be situations when release of feeling would be distinctly contraindicated and that a patient might better be supported in his own attempts to control his feelings.

Similar questions arose as they worked with acutely anxious patients. Both students acknowledged a strong feeling that one of the unequivocal functions of a psychiatric social worker was to reassure patients and to relieve their anxieties. When directly asked what were the anxieties they were attempting to relieve and on what basis they were proffering reassurances, they, themselves, experienced considerable discomfort. It was with difficulty that they were helped to see that anxiety really was natural in certain situations and would remain as long as the causation continued and that treatment might at times lie in handling not the problem but the anxiety itself, while at other times the reverse might be true. Theoretically, they recognized that sustained anxiety might have constructive values in modifying responses and altering behavior, but practically they encountered a strong desire in themselves to act at once to break the tension.

Some dismay was at first experienced when the students realized that a good part of their practice would be with patients who were at the point of discharge from military service. At first they saw this as representative of a very casual service to patients who were, so to speak, on their way out. Very quickly, however, they began to appreciate the significance of the transition point as revelatory of unsuspected ambivalences and profound conflicts which ran the gamut of all they had learned of human conflicts in their training hours. They quite quickly recognized the discharge period for each patient as a condensation not only of his service experiences and attitudes but of his past life, his fears and his desires for the future, and with the insight thus gained they consciously sought for skill in handling these interviews.

AGENCY CONSIDERATIONS

It was felt, on the whole, that, despite occasional interruptions and distractions, adequate supervisory time on both a formal and informal basis was made available to the students. Time was also made for reading of their records and for conferences on the selection of material suitable for use in their thesis. Their interests were placed first, and administration and staff willingly accepted this altered relationship.

In point of fact, however, the hospital continued to increase in size, administrative responsibilities connected with the supervision of workers in several offices mounted, the Dependents' Unit and the medical specialties became more and more active, and the policy of concentrating supervisory time and attention on students began to appear to be a shortsighted one. Unevenness of supervision at times permitted the accumulation of small problems which soon involved the total staff, and, in a closely related group, this sooner or later meant students, too.

A certain consistent responsibility was due from the supervisor to the Red Cross scholarship workers now on their first assignments as well as to other workers. Time was apportioned among these and necessary medical meetings as well as staff and group meetings. Little was left with which to plan these meetings in ad-

vance. More important, very little time was available with which to respond to the interest and eagerness of staff workers in their own fields; to attend outside meetings related to cardiac illnesses, tumors, and tuberculosis; to read current professional literature along with the workers in the fields; and to enter wholeheartedly into their readiness to expand their own work on each service, to experiment, to create. This, in turn, meant that this much extra stimulation in the fields of case work and medical social work was denied the students as well as the regular workers.

While the supervisor was fortunate enough to have had a brief ward experience on the neuropsychiatric service and had so become familiar with the interests and practices of the medical officers as well as with ward procedures, once the heavy turnover of staff began, she was unable to keep abreast of changes except at second hand. As one replacement followed on the heels of another, she had no opportunity to develop with psychologists and other specialists in allied fields that kind of close relationship which springs from a soundly interpreted picture of what each is performing and wherein it is complementary to the other. The fruits of this kind of developed relationship were likewise denied the students. The supervisor, by reason of compounded responsibilities, was hard put to it, too, to keep abreast of the attitudes of staff and patients around fast-changing military directives. All this meant, in the end, a thinness of supervision, a less lively and responsive and a more academic tone.

There was almost no opportunity at all to know the students' own patients, to participate in the students' conferences with doctors, to visit the wards during recreational activities and students' and doctors' ward rounds, to participate in the ward life itself. This further denied to the students a richness and a color that should have been present in supervision.

RELATIONSHIP TO SCHOOL

Contacts with the school were regular and helpful, and the supervisor has throughout felt that she had the sincere and sustained support of the school. Distance and pressures of work on both sides made ideally close co-operation an impossibility. Through the persons of the student faculty advisers, many of the points here described were exhaustively cleared; but personnel changes occurred among the faculty, too, and there was no opportunity to offset the effects of such changes. The student faculty advisers made a great effort to understand the thinking and the points of view of the field-work supervisor, to follow and to reinforce and support these in their conferences with students. They were, however, in the position of following our thinking and our activities, and ours was, as has been pointed out, a fast-moving and a turbulent program. It was felt to be a matter of regret that the school was able to give so little direct recognition to the rapid pace of our program, to its unique values and its special emphasis, and to the fact that, although it differed greatly from the classical psychiatric setting which the school continued to stress, it provided, nonetheless, a contemporary setting with effective learning possibilities for students of psychiatric social work.

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NOTES AND COMMENT BY THE EDITOR

THE WORLD HEALTH ORGANIZATION INTERIM COMMISSION

MANY social workers have been interested in the Fourth Session of the World Health Organization Interim Commission, which met at the Palais des Nations in Geneva in September and which gave new support on an international scale to the long fight against disease when representatives from fifteen nations decided on positive, aggressive action to combat such world-wide diseases as tuberculosis, malaria, venereal disease, and influenza. The First World Health Assembly is expected to be held next spring or summer.

Because tuberculosis has assumed epidemic proportions in some countries, the W.H.O. Interim Commission decided to send small demonstration teams to countries asking for assistance in order to initiate intensive programs of BCG vaccination, which has been used widely in some countries to prevent tuberculosis; and it was agreed that information on its use should be made available to all peoples desiring it.

The Interim Commission agreed that the second meeting of the Expert Committee on Malaria should be held in Washington in May, 1948, during the fourth International Congresses on Malaria and on Tropical Medicine, so that other international authorities might contribute information. Sections of the Expert Committee's report cited new antimalarials and DDT as "weapons of great practical value." The report said that DDT at last seemed to offer a relatively cheap means of controlling this disease.

To help combat or prevent another world-wide influenza epidemic such as took place in 1918 and 1919, an International Influenza Centre in England was authorized; and the American offer to make available the National Institute of Health in Bethesda, Maryland, as a regional influenza laboratory was accepted.

An Expert Committee on Venereal Diseases and another for revising existing sanitary conventions will be set up in the near future. Because of the alarming increase in these diseases during and after World War II, it is hoped that international experts in this field will be able to meet before the end of the year to plan a world-wide campaign. A report to the Interim Commission said that penicillin offered some countries "a future possibility in control" of these diseases, but the drug is not yet available in sufficient quantities to permit its use on a world-wide scale.

An Expert Committee on Quarantine, previously authorized, was asked to consider, during its first meeting on November 24 in Geneva, an international schedule for disinfecting aircraft, in the hope that such a code would be a boon to international transportation.

It was decided to call the attention of the First World Health Assembly to the problem of alcoholism, and the Interim Commission asked that a study be made in cooperation with other United Nations agencies.

Plague, which has been an international medical problem for more than a thousand years, was placed on the agenda for the First World Health Assembly.

The W.H.O. Interim Commission decided to hold the First World Health Assembly in the Western Hemisphere, with the final selection of a definite site left to the chairman, Dr. Andrija Stampar, professor of public health and social medicine, University of Zagreb. The World Health Assembly must be held within six months after the twenty-sixth United Nations member ratifies the W.H.O. constitution.

To carry on the necessary work of protecting the health of the globe, the Interim Commission approved a 1948 budget of $1,528,324 for its general fund. In addition,

$1,500,000 from U.N.R.R.A. will finance a field service program with missions of international experts to countries asking for outside assistance in setting up and managing medical and health programs and will supply funds for helping war-devastated countries rebuild their medical libraries, and approximately two hundred foreign fellowships for doctors, nurses, and public health experts to study during the coming year under a W.H.O. exchange program whereby scientists and medical specialists share in advances of medical knowledge on a world-wide basis. Fellows are nominated by their governments in accordance with a program approved by W.H.O. to foster the dissemination of medical knowledge and progress to the widest extent and to aid in rehabilitating public health in those countries most seriously devastated by war.

"IMPROVING WORLD STATISTICS"

THE *Review* noted earlier the important statistical congress held in Washington in September. We are also glad to call attention to some of the important recommendations of the Statistical Commission of the United Nations, which met for its second session early in September. Meeting on the eve of the World Statistical Congress, the *Weekly Bulletin* of the U.N., in an article on "Improving World Statistics," tells us that the commission reviewed the statistical needs of the United Nations in advance of discussions on related topics by the assembled statistical leaders of the world.

Two features are said to be essential "in the setting up of an effective international statistical system within the United Nations. First, there must be a strong central unit continuously responsible for meeting the statistical needs of the United Nations, and for co-ordinating the work of the United Nations and the affiliated specialized agencies. Second, the system must develop and employ standard definitions and classifications, and secure their use by governments and intergovernmental agencies."

The Statistical Office of the United Nations has already been established in the Secretariat to serve the statistical needs of all the departments and organs of the U.N. and to be a co-ordinating agency for the statistical activities of intergovernmental organizations. The office is now publishing the *Monthly Bulletin of Statistics* and is working on the preparation of statistical yearbooks.

The first recommendations in the commission's report to the Economic and Social Council was for the taking-over of the responsibilities of the old League of Nations. The League was responsible for securing improved statistics throughout the world under the terms of the International Convention relating to Economic Statistics, which was signed at Geneva in 1928. The present recommendations would mean that the commission will take over the functions of the League's Committee of Statistical Experts, and the commission had forwarded a draft convention which, if adopted, will effect this transfer.

The commission urges that the secretary-general arrange to receive from all specialized agencies a draft of each statistical questionnaire prepared by them, in order to promote co-ordination of the statistical activities of international organizations. The commission also recommended that the secretary-general should "periodically prepare and circulate to all agencies descriptive and analytical notes on the content of, and development and changes in, the statistical programs of the specialized agencies and the United Nations."

The commission also requested that the secretary-general give special attention to formulating an integrated plan for the publication of international statistical yearbooks in the fields of agriculture, labor, health, aviation, and education.

The commission indorsed the plans for various international censuses in 1950, including the 1950 population census and the proposed 1950 world census of agriculture, the importance of which is emphasized. Support of a 1950 census of the Americas was

again noted. These will be the first postwar censuses, and present plans suggest that more countries will take censuses in 1950 than has been the case in any other single year.

A Committee on Industrial Classification to formulate proposals for the adoption of an international standard classification of types of economic activity was again established; but, because of the close interrelationships in classification of industries, occupations, products, commodities, etc., it was renamed the Committee on Statistical Classification and is to consider all kinds of classifications used for statistical purposes.

The Statistical Office of the United Nations is said to be receiving a large number of requests from official sources for "general purposes figures," such as statistics on population, national income, and the total external trade of each country, and the Statistical Office "requests the countries either to supply the statistics themselves, or to review estimates submitted."

The commission recommended that every effort should be made to widen the geographical coverage of the Statistical Office. Where reliable data are not available, but when estimates can be made, the commission proposes that the Statistical Office should procure or construct them to be sent to the governments concerned for comment.

The commission approved the Secretariat's plans for a national income publication and also its efforts to revive the League's statistical publications, interrupted by the war.

The commission suggested to its Subcommission on Statistical Sampling the possibility of a manual for use by national governments. The importance of applying sampling methods to agricultural censuses and family budget inquiries, as well as to population censuses and income statistics, is noted.

There seems to have been no discussion of social welfare statistics—an omission that must surely be corrected when the commission meets again.

U.N.R.R.A. IN CHINA

IN THE last months of U.N.R.R.A.'s existence in the Far East serious political difficulties have been reported. A special correspondent for the *New York Times* has said that new problems in China have made it difficult to carry out the U.N.R.R.A. policy of "no political discrimination in distribution." As we go to press, the *Times* article has reported that

> the unusual Chinese relief situation developed when various United States envoys were attempting to foster a Chinese government that would include Nationalists and Communists. Relief was first handled by the Chinese Nationalist Relief and Rehabilitation Administration. As the rift between Communists and Nationalists continued, the Communists set up their own relief organization. Small amounts of relief supplies then went into North China famine areas under supervision of the three groups.
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> When hostilities barred this arrangement, the U.N.R.R.A. negotiated a commitment from the Chinese Government by which 83,000 tons of relief supplies were to go into territory held by the Communists, of which 33,000 tons were delivered. However, all shipments to North China, to Nationalist as well as Communist territory were cut off last July pending the negotiation of more satisfactory arrangements for getting relief into the Communist-controlled areas.
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> A partial agreement was negotiated with the Chinese Government in August, but it has not yet been accepted by the Communists. The situation has become increasingly complicated since, with more military hazards to the distribution of supplies. The U.N.R.R.A. has been evacuating its personnel from Communist areas because of these hazards.

But the U.N.R.R.A. policy has been "no political discrimination in distribution." Is it impossible to carry out this policy in China?

It is understood that 50,000 tons of relief supplies worth about $6,000,000 earmarked for Communist-held territory were being impounded in warehouses in China. It is probable that the "obstacles imposed by military necessity" must be faced with realism and that, if it is impossible to give aid to all,

U.N.R.R.A. should not therefore refuse to help where it is possible. Certainly, the Communists need such relief and medical supplies as can be sent into that still war-torn area.

OUR FRIENDS IN PUERTO RICO

SOCIAL workers have had a long-time interest in Puerto Rico. Many of our schools of social work have welcomed the excellent students who have come from Puerto Rico and who have taken higher degrees in our American schools. The development of an accredited school of social work in the University of Puerto Rico, which has been admitted to membership in the American Association of Schools of Social Work, has also brought together social workers from the island and the mainland. For nearly twenty-five years the United States Children's Bureau has also worked with the child welfare agencies of Puerto Rico, and many social workers from the island have been well known and have many friends among us. But are we doing all that we could do to make this part of our country as prosperous as it should be? The following editorial from the *New York Times* under the heading "The Tragedy of Puerto Rico" would seem to indicate that we have not done our part in the period of nearly half a century that Puerto Rico has been part of our country.

One of the saddest of the world's problems is illustrated by the heavy Puerto Rican immigration into this city. The story is simply one of a population too great for the island's resources, yet unable to find adequate outlets elsewhere. New York City alone is thought to have 600,000 Puerto Ricans, or nearly two-thirds the whole population of Puerto Rico when the United States took over in 1898. Now the island has more than 2,175,000 inhabitants struggling for a livelihood, and the estimated 2,000 a month who are coming to this city are considerably less than the natural increase.

It is easy to see that the newcomers are not brought here under the best conditions. Some of them ride "bucket-seat" planes; some have even had to stand during a fourteen-hour trip; others come more comfortably by steamship. Once arrived, they have trouble getting employment, they add to a serious housing situation, some have to be hospitalized, and many go on relief or become candidates for it. This is New York City's aspect of the problem. But what is to be said of Puerto Rico's aspect? These immigrants are fugitives from an appallingly low standard of living at home, from rural and city slums, from the same lack of opportunity which a generation or more ago drove millions of Europeans to our shores.

A vigorous attempt to develop Puerto Rican industries, plus planned emigration for those who still cannot be supported on the island, is an easy remedy to suggest. It is not an easy one to carry out. Puerto Rico needs all the aid and sympathy we can give it. If all its people cannot subsist at home above the slum level some of them must be helped, in an organized way, to find homes elsewhere. We have a responsibility, voluntarily assumed and close at hand, which we cannot evade.

JUVENILE DELINQUENCY IN BERLIN

IN THE monthly magazine, the *Magistrate*, published in London for the British Magistrates' Association, there appeared not long ago an account of a survey of "Juvenile Delinquency in Berlin" conducted late last year by H. W. Maw, a Quaker, who had been working with the British Friends' Relief Service. It has been reported not infrequently that one of the difficult conditions in postwar Germany is the great increase in juvenile delinquency at a time when the means of helping children constructively have been so completely destroyed. We quote below some of the interesting sections of the article in the *Magistrate* describing the results of the survey:

Among the principal contributing factors of delinquency the report mentions social insecurity, the breakdown of family life and a complete loss of values. The Nazis deliberately broke down the authority of parents. Personal loyalty to parents was cheapened and minimised to the greatest possible extent. The State became the authority and the child was encouraged to disobey his parents if the parents' wishes conflicted with those of the State. "The only thing that can be said for the regime is that

among delinquents at one time Hitler youth made up the smallest percentage because with all their regimentation their time was fully occupied." But let no one take that as an argument for regimentation!

What the Nazis began, the war increased. It completed the breakdown of family life by killing or capturing large numbers of the male population, by the destruction of houses and the consequent overcrowding—"as many as six families sharing a flat," and the continual difficulty in obtaining food and fuel and the ordinary necessities of decent life. The widespread deterioration of social discipline, the chaotic condition of education, the lack of accommodation, making it physically impossible for young people to be occupied indoors in their leisure hours, the necessity of scrounging to obtain food, resulting in the lowering of standards in relation to black market dealings and even to stealing, all contribute to the great increase in delinquency. The lowering of moral standards, deliberately begun by the Nazis, and increasing under war conditions and, it is alleged, under the occupation, combined with the difficulty of finding suitable employment for girls, has resulted in a very large increase of sexual misconduct, particularly among girls, and it is estimated that between 20 and 30 per cent of Berlin "youth in danger" have been or are infected with V.D.

The report classifies the offences committed by juveniles under four main heads: (1) poverty thefts, (2) adventure thefts, (3) offences by habitual delinquents with crime disposition and psychopathic cases, and (4) sexual misconduct.

As to poverty thefts: there is a very large increase in such cases. The majority of these delinquents are not basically anti-social. They commit these offences not through any mental kink, but from the pressure of continual hunger and the normal human impulse to have what they need. They have succumbed at the breaking point where scruples yield to hard physical need. Sixty or seventy per cent of these offences were "economic"—stealing ration cards, food, coal, or in black market dealings. Bread or shoes have been stolen and more valuable things lying alongside have been left untouched. Young lads steal money to pay school or training fees, or to help the family budget; bicycles are stolen because of lack of transport or shoes to go to school. . . . .

The ratio of really serious crime has increased alarmingly. "In July and August the number of murders committed by juveniles equals the total of the past four years." Girls of 15 and 16 were among 15 juveniles awaiting trial in August, 1946, for murder for the purpose of robbery. Most serious crime by juveniles consists of burglary, robbery, and murder.

The proportion of boys to girls is about 100 to 40. The girls are largely in the sexual misconduct category. Very few girls take part in organised stealing.

The majority of young delinquents came formerly from the working classes. Now they are much more evenly spread among the working, middle and upper classes. It should be remembered that in Germany, as elsewhere, the majority of law-breakers are not delinquents in the sense of being criminally minded. But they all have to go before the same courts, and go to swell the official statistics for their particular age groups. This fact needs to be constantly kept in mind when studying statistics of juvenile delinquency elsewhere.

As to combative measures, the report mentions that the Church, which must be held very widely responsible for the present situation by not doing what it might have done in the past to maintain high moral standards and ethical values, is nevertheless attempting useful work in the care and re-education of delinquents and youth in danger and in training welfare workers in its own institutions. But it is not doing as much as it should and is still too much inclined to mix itself up with politics.

There are in Germany no probation officers as we know them. Work in relation to delinquency is included in the duties of social welfare officers, specially trained for the work—the training normally takes two years, but the profession is not popular with men. These officers' duties comprise every kind of welfare work, so that probation work as we understand it is a very small part of their responsibilities. There are 1,100 of them, but the report states that two or three times that number are needed. Their duties include that of preparing reports on cases coming up for trial similar to the reports which the local education authority or the probation office is required to prepare for English juvenile courts. But they also include the duty of looking after young prisoners on return from serving their sentence, or while on remand. And for those who are neglected, beyond control, mentally defective or otherwise difficult or in danger they try to find homes, institutions or the right person to help them. . . . .

It is not surprising to find the report stating that the police, as a combative force in relation to juvenile delinquency, is unreliable and its training insufficient. The courts are considered under the laws of 1922 and 1923, with the later Nazi implications removed. Germany has had juvenile courts since 1908 so there is no lack of experience, but the judges, though "excellent people," are too old for the job—the average age is 61! There are too few of them. They have no time or transport to keep in touch with young prisoners, or with the homes, prisons and other institutions to which they send the delinquents.

Under German law no boy or girl can be put on trial below the age of 14 years. They are regarded as juveniles up to the age of 18, and in several courts in Berlin some have been included under the juvenile law up to 21.

Under present conditions it is difficult to get from the report a clear picture of the position with regard to the trial of offences by juveniles, since there appears to be some overlapping between the German and the military courts. For instance, one is left to presume that an offender under 14 is left to be admonished and cared for by the welfare officer so far as German law is concerned, but it is stated that the military courts punish severely below that age, "so that boys and girls are sometimes 'too young for the existing' institutions." The procedure in the German and the American courts is different. In the former it is extremely formal and rather mechanical. In the American military court the child is present during the whole proceedings and hears all that is said. "It seems that this may not be always beneficial to the child," says the report. The Germans are "deeply impressed by procedure, and fairness and concern for the delinquent's correction." The military courts have more time to deal adequately with the fewer cases brought before them. But the German courts have so many cases that the pre-trial period of detention is sometimes as long as three months. . . . .

There are only 36 institutions left in Berlin, with less than 2,000 places, but about 4,000 juveniles detained in them. The period of detention ranges from 3 months to 5 years. . . . .

The imprisonment of juveniles would not appear to be under the same restrictions as in England. "Too many juveniles are imprisoned, due to lack of place in corrective institutions," says the report.

There are a number of recommendations in the report for dealing with the problems of delinquency, many of which are peculiar to Germany as a conquered and occupied country. But one or two passages are worth quoting:

"It is not sufficient to attempt to cure juvenile delinquency only by more and better youth welfare and relief officers, foster parents or homes, important as these are. It must be attacked and prevented *at the source* by giving some stability and security to the nation, and the following out of a bold decisive policy which fundamentally rests on impartial Christian standards.

"The question of youth movements must be settled to ensure that all youth may have the right opportunities for the best use of their leisure time. . . . .

"It is essential that juveniles should be brought to trial as soon as possible 'after the offence,' otherwise the effect of the punishment is zero, and as soon as they come out they begin all over again. . . . ."

It is also suggested that an institution to which a child is committed should maintain contact with the child's home, and parents should be invited to "open evenings" at the institution. In this way the confidence of the parents and their co-operation may be won, and so when the child leaves the institution he will find, in his home, conditions which tend to continue the good work begun in the institution. To-day, in so many cases, ... it is often exactly the reverse.

TUBERCULOSIS IN GERMANY

THE tragic result of cumulative deprivations in Germany is dealt with by a special correspondent of the *Manchester Guardian*, who wrote from Berlin as follows:

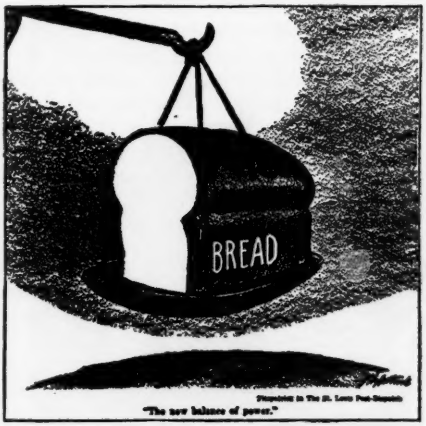
Although the Allied and German medical authorities have so far checked diphtheria and venereal disease, and have averted any major epidemics, they unanimously agree that tuberculosis is by far the most serious danger to the health of the German people to-day. Just how serious it has become is not at once clear from the scattered official statistics published on the subject. A current problem tends to lose shape and significance. The danger, which grows by stealth, requires appraisal and review. Only thus can it be recognised.

At the moment deaths from tuberculosis in all Germany average about 200,000 a year. This

estimate of the Berlin representative of the State committee for tuberculosis cannot be checked and it does not pretend to be exact. It compares with the following figures: 42,000 in 1939, 55,000 in 1941, and 117,000 in 1945.

Statistical sources have led German doctors working independently, to assess the number of people suffering from tuberculosis at five times the number of deaths. This would give totals of 759,000 for 1946 and roughly one million for this year. . . . .

Living conditions play the biggest part in the battle of tuberculosis. To-day the purchasing power of the mark has sunk disastrously. Low earners are now in an immense majority, and



"The new balance of power."

their lack of money to pay for extra food and medical treatment is likely to result in a still higher incidence in tuberculosis. . . . .

Rations are inadequate. Not only has the caloric value of the tuberculous person's food fallen from 2,800 to 1,500 but he is missing those very foods which give him the body-strength and energy to fight off his disease.

Berlin lacks beds for tuberculous patients. There are only 30,000 medically attended beds in the whole of Germany, for the districts best provided before the war were in the Austrian provinces . . . . and there has been a further loss from bombing and from the transfer . . . . of the territories east of the Oder-Neisse line.

There is, surprisingly, no shortage of general medical personnel, although nurses are loath to risk being infected. . . . . But there are few specialists left. In Berlin there are only two doctors skilled in operations for tuberculosis of the lungs. . . . . There are instruments but few X-ray or photographic apparatus. Many of these have been lost or broken and cannot be repaired. Others are immobilised by lack of transport.

Bed linen is very scarce. . . . . In Berlin United States and British Military Governments have done what they could. From American stocks have come mattresses, sheets and blankets; the British have entirely fitted up the Forest Hospital in Spandau. Soap and washing powder are two of the other most pressing needs.

A matter of balanced diet.

Commenting editorially, the *Guardian* said:

There are many things which can and must be done to combat the threat of tuberculosis in Germany. First there must be more food for patients—above all, in the shape of fats. It may be that international charity can finance a scheme to provide this. More beds must be found to replace the 10,000 lost in Eastern Germany and the 5,000 no longer available in Austria and Switzerland. Germany needs at least 30,000 more attended beds. . . . . There must be more soap, linen, rugs, easy chairs, and ingredients for hot drinks. There must somehow be more doctors and more sanatoriums for special forms of tuberculosis. There must, too, be money, and

a German expert has suggested that the whole population should contribute one "tuberculosis mark" monthly. This would give an income of 1,000,000,000 marks a year. With this apparatus at least could be repaired and many basic articles of equipment bought. Lastly, there must be centralised control measures to deal with tuberculosis and a clearly organised campaign. Germany faces a very terrible danger. Decentralised, divided, and weak, her national health may be undermined while we wrangle with reparations and quarrel over Constitutions. The brains of the world can in time put her on the high road of progress, but it seems that only the charity of the world can save her from falling by the wayside in the meanwhile.

Duffy in The Baltimore Sun.

"The Empty Dinner Pail"

POLAND STILL IN NEED

THE magazine, *Poland of Today*, published by the Polish Research and Information Service, New York, is very critical in a recent article about our State Department's announcement of July 23 that Poland was to be canceled from the list of countries receiving American aid. The Department of State apparently based its decision on the report of a three-man mission headed by Colonel Harrison, special assistant to Secretary of Agriculture Anderson. The article says that, after stating that the food situation of Poland is better than that of Greece, Italy, Austria, western Germany,

and Japan, Colonel Harrison reached the following conclusions regarding Poland: (1) grain and other foods are available to meet the minimum food needs of the Polish people generally for the balance of this calendar year; (2) imports of medicines and supplementary foodstuffs, for relief of special groups such as children, orphans, sick, and aged, appear justified.

The article then comments:

> These conclusions and the ensuing decision of the State Department caused general surprise in Poland. Obviously Col. Harrison, who spent only a relatively short time in Poland, did not have sufficient opportunity to investigate thoroughly the food situation there.
>
> In point of fact, the situation is considerably less rosy than it would appear from the report of Col. Harrison's mission. Unquestionably Poland did achieve great progress in the rehabilitation of her agriculture, and she did so under the most difficult conditions—after the country was laid waste by the war, and devastation caused great shortages of fertilizer, agricultural machinery and livestock (70 per cent of the prewar livestock was destroyed). Still, it is a far cry from her actual achievement to the picture painted in Col. Harrison's report.
>
> This is borne out not only by Polish sources, but also by the findings of U.N.R.R.A., an organization to which Poland is deeply indebted for the aid it extended to her farmers. These findings cannot over-emphasize the fact that the current year is a particularly difficult one for Polish agriculture and that consequently prospects are by no means bright.
>
> This past winter was exceptionally hard. Forty-four per cent of the wheat and 23 per cent of the rye were destroyed by frosts. The frozen areas had to be tilled and sown once more. But that was not all. With the spring weather came floods which destroyed about half a million acres of cultivated ground and the floods were followed by a drought which in turn diminished the productivity of Polish farmland.
>
> The results were disastrous. As early as the beginning of 1947 a United Nations committee, which had investigated the Polish situation, estimated the Polish food shortage at $139,000,000. The findings of the Food and Agricultural Organization (FAO) give an even graver picture of the situation.
>
> The months to come will be particularly grim. The necessity of re-sowing vast areas not only consumed an enormous amount of seed but also caused a delay in the harvest. Consequently, major quantities of grain will not appear on the market before the end of the year and even then they will not be sufficient to meet the basic needs of the population.
>
> Polish people were surprised by the decision of the State Department. "The people of Poland," says the Warsaw daily, *Rzeczpospolita* (The Republic), "had a right to expect help by reason of their contribution to the cause of victory and to the economic rehabilitation of Europe. Naturally they feel hurt by the decision of the American Government. They fail to understand this decision which is so contrary to the principles avowed by the State Department in determining its policies of sending food to Europe."

"THE PEOPLES' CHARTER" INAUGURATES FILM SERIES

THE *Review* has noted some of the important documentary films from time to time, and we are glad now to call attention to the first film to be produced by the United Nations—a two-reel documentary, which was released in the United States in time for United Nations Week last September.

"The Peoples' Charter" was produced by the Department of Public Information and is presented by the U.N. Film Board. Over a quarter of a million feet from seventeen nations was screened by the U.N. film unit in selecting shots for the picture, which shows the birth of the United Nations idea, then the founding and development of the organization, and, finally, its aims and problems as seen by the peoples of the world.

The film stresses the point that the success of the United Nations depends on the interest, faith, and action of the people behind the governmental representatives sitting in the U.N. councils.

Wide demand by American organizations, schools, and churches for a film about the United Nations led to the decision to release "The Peoples' Charter" in 16-mm. size without delay. Prints were made available at nontheatrical film exchanges throughout the United States in time for United Na-

tions Week. Meanwhile, the film was exhibited in motion-picture theaters in Canada and the United Kingdom during the General Assembly session.

French- and Spanish-language versions are now being prepared, and a Portuguese-language version was shown in theaters in Brazil during the recent Inter-American conferences. Chinese- and Russian-language films are also under consideration.

"The Peoples' Charter" is the first of fourteen United Nations short films that will be produced for the U.N. Film Board in eleven countries. The second film, "Maps We Live By," dealing with the international problem of preparing maps of the world, is now being completed by the National Film Board of Canada and was scheduled for release in October.

C.R.A.L.O.G.

A STATEMENT released by C.R.A.L.O.G., the Council of Relief Agencies Licensed for Operations in Germany, last summer showed that a total of 35,500,000 pounds of relief materials had been shipped to Germany over a period of fifteen months. C.R.A.L.O.G., a federation of fifteen American voluntary agencies, chiefly church and labor groups, was started by a presidential directive on February 19, 1946. The member-agencies include the American Friends Service Committee; the Brethren Service Committee; the Church World Service, comprising twenty-two Protestant denominations; the Committee on Christian Science Wartime Activities of the Mother Church; the Congregational Christian Service Committee; International Migration Service; International Rescue and Relief Committee; Labor League for Human Rights (A.F. of L.); Lutheran World Relief; Mennonite Central Committee; National C.I.O. Community Service Committee; Russian Children's Welfare Society; Tolstoy Foundation; the Unitarian Service Committee; and the War Relief Services, National Catholic Welfare Conference.

The director of C.R.A.L.O.G. (Edward M. O'Connor) said in the *New York Times* that material that had been sent represented more than $25,000,000 worth of food, clothing, and medical supplies.

"During the past year CRALOG has provided supplementary feeding for over a million sick and undernourished children," Mr. O'Connor said. "In addition, special aid was given thousands of nursing and expectant mothers, victims of Hitler and expellees from neighboring countries. Hospitals, schools and other public institutions received medical supplies, food, bedding and clothing valued at several million dollars. At the personal request of Gen. Lucius Clay, CRALOG shipped approximately 40,000,000 units of insulin into the American zone to supplement pitifully small stocks available there."

"THE GOOD AND THE CLEVER"

WHEN the Master of Balliol delivered the Founders' Memorial Lecture at Girton College last year, it was interesting that he took for his text the verses of Miss Wordsworth:

> If all the good people were clever,
> And all clever people were good,
> The world would be nicer than ever
> We thought that it possibly could.
>
> But somehow 'tis seldom or never
> The two hit it off as they should.
> The good are so harsh to the clever,
> The clever so rude to the good!
>
> So friends, let it be our endeavour
> To make each by each understood;
> For few can be good like the clever,
> Or clever, so well as the good.

The Master of Balliol's address was interesting to a social worker because he had been "reading lately an article describing the history of case work, the application of scientific method to charity," and he selects a social worker, Miss Octavia Hill, as "one of the most efficient and capable of women and at the same time . . . . a saint."

Octavia Hill showed in a rare degree how few can be good like the clever, or clever so well as the good. And to read the subsequent history of case work is to see how hard it is to remain human and personal without being sloppy and sentimental or to be efficient and scientific without being hard and inhuman.

"OUR NEGLECTED INSANE"

DR. GEORGE S. STEVENSON, the well-known medical director of the National Committee for Mental Hygiene, has wisely published an article in a popular magazine (*Look*, October 28, 1947) about "Our Neglected Insane." Fortunately the Illinois Department of Public Welfare saw the importance of the article and allowed photographs to be made in some of the Illinois mental hospitals. Dr. Stevenson points out that, although "any psychiatrist will readily admit that we know too little about the human mind," we do know that mental illness varies considerably in intensity—that the severe cases must be hospitalized either because they are dangerous or because only in the hospital can they obtain the complicated treatments they need. However, Dr. Stevenson, in this popular article, makes it clear that the less severe forms of mental illness are far more numerous—that there are "the psychoneuroses in which one's sensitivities are so great they consistently interfere with daily work." He also calls attention to mild cases of mental deficiency in which the individual does not learn in school as well as the normal person and explains that, although these and other mild cases seldom need hospitalization, they do require psychiatric treatment." Dr. Stevenson says:

> Yet little is being done for them. It is a vicious process. For it is because the mild cases are neglected that they become worse and overload the hospitals.
>
> The whole problem comes from general ignorance of the entire significance of mental illness. Most people still feel such distaste about the whole idea of mental hospitals that they would like to forget about them entirely. It is one of the reasons hospitals are often set off at distant and inaccessible places. Relatives and friends find it almost impossible to visit the patient and check on his care.
>
> As a result food, clothing, medical treatment, exercise, recreation, cleanliness and protection from abuse are in general at a low level. Patients may be provided with adequate food, yet they often go hungry because there are not enough attendants to feed patients who are not able to care for themselves properly.
>
> They live in congested, foul-smelling wards. They hurt each other. Often as a result they die.
>
> What is the answer?
>
> Last year, in the passage of two acts, our Federal Government took the first major steps to improve the mental health of our nation.
>
> One law, the Hospital Survey and Construction Act, authorized $375,000,000 for the construction of hospitals and health centers. The other, the National Mental Health Act, provides for three programs: intensive research into the causes and treatment of mental illness, grants-in-aid for the training of greatly needed personnel and grants to the various states for the improvement of local mental-health services.
>
> All of these activities depend, however, on the financial participation of the state.
>
> In the final analysis, this means but one thing. States where the people are interested and aroused to the urgency of the problem will benefit. Others, which lack pressure from the individual voters, will continue to lag behind. And the relatives and neighbors of these negligent voters will continue to rot in inadequate, outdated institutions.

Dr. Stevenson wisely adds a list of what might be included in "what you can do to help":

1. You can visit your nearest mental hospital. Speak to the superintendent and get to know the needs of the hospital and those of its staff.
2. You can talk and write to state legislators to make sure they know that the voters are interested in decent and humane hospitals for the insane.
3. You can volunteer services for one day a week to the state hospital directly or through the Red Cross, and you can encourage others to do the same thing.
4. You can join with others interested in your own state mental-hygiene committee. Or you can contact the National Committee for Mental Hygiene, 1790 Broadway, New York, N.Y. This committee will help you direct your efforts where they will do the most good.
5. You can read the fourth chapter of Genesis, 9th verse, and think through the meaning of those famous words: "Am I my brother's keeper?"

"PSONGS FOR PSYCHIATRISTS"

THE following is one of several "psongs" from *Punch* that may interest our readers. The subtitle of this "psong" is "Emulous Emily *or* The Case of the Comparative Bohemian."

I am the youngest of us all,
And really, in a sense,
The most intensely musical
And vitally intense.
Our home-life was a soulless load
Of all that's most provoking.
We lived in Abbotsbury Road,
And went to school in Woking.
Our teachers all preached Self-control
And governed by Repression.
I had no contacts for the Soul
Or scope for Self-expression
Till my Libido—Kate suspects—
Electrified, by letter,
The man who works the Sound Effects
At Putney Hill Theatre.
. . . . . .
Our childhood was a cultural void—
Strait-laced and highly strung.
They didn't even read us Freud
When we were very Jung.
We tried to key our lives in tune
With artists whom we met;
And Jane got off with a Bassoon,
And Kate with a Quintet,
And Pamela with Poushnikoff.
Then why've I not done better
Than Alf, who makes the Noises Off
At Putney Hill Theatre?

—P. B.

"COURTS-MARTIAL REFORM"

FOLLOWING a discussion of the subject of "military justice,"[1] our readers will be interested in the following editorial which appeared in the *New York Times* when our last number was in press:

The one most important, and most controversial, change suggested in the system of military justice by a House subcommittee is that which would make the Judge Advocate General's Office a branch of the Army divorced from the line, with a separate promotion list. Bar Association committees that studied the problem, including the committee appointed by the War Department itself, were unanimous in the conclusion that such action is a fundamental and necessary reform. . . . .

Adoption of this change would help to bring military justice more nearly into line with civilian standards, to remove suspicion from courts-martial decisions and reviews, and to give the accused soldier a feeling that his alleged transgression was being properly considered on the evidence and decided according to the law. There should be no fundamental difference in the application of military law and of civilian law. The law is different. It has to be. But its application should be the same. In civilian life a man cannot be charged, prosecuted, judged, sentenced and then have his sentence reviewed by the same individual. Yet that is the situation in effect in the Army.

In a peacetime volunteer Army the present system of military justice works well enough. The Army man accepts his special place, the special rules that are applied to him, the special kind of justice that is meted out. But in national emergencies, in wars, the armies of the United States are filled mainly with men fresh from civilian life. Their encounters with the military system are harsh enough, without the added one of a different conception of justice and of administration of laws.

Most of the other suggested reforms—permissible seating of enlisted men on courts trying enlisted men; subjection of officers to courts-martial for offenses similar to those warranting courts-martial for enlisted men; right of the accused to demand counsel during pre-trial investigation; and the several others also seem to us to be sound. They could have little meaning, however, if the fundamental reform of an independent Judge Advocate General is not also accepted.

Everyone has agreed that under the system that was in effect during the war injustices were done. Careful studies have been made of the reasons. Most of the Bar Association committees have included young lawyers who had themselves served in the Army during the war and knew at first hand what these injustices were and had first-hand knowledge on which to base their decision as to the cause. Their unanimity on the necessity for an independent Judge Advocate General thus carries added weight. We hope that the suggested Army re-

[1] See this *Review* XXI, 197 and 395.

forms are adopted and that similar reforms for the Navy also will be adopted. The Navy bill is still in committee and hearings have not been held.

FURTHER FEDERAL FUNDS FOR CHILD CARE

AN ACCOUNT of the new federal funds made available under an amendment to the Social Security Act, Title V, Part 3, published in the *Child* explains that these funds may now be used to pay for temporary boarding care for special groups of children.

An amendment to the regulations for administration of the act enables State public welfare agencies to develop, under State plans approved by the United States Children's Bureau, such services and facilities as (1) subsidized boarding homes for temporary care of children needing shelter, detention, or emergency care, (2) temporary foster-family care of nonresident children, and (3) care of some unmarried mothers and their babies when other facilities are lacking. Previously boarding-home care could be paid for from Federal funds only under certain emergency conditions.

Now that the regulations permit the use of Federal funds to pay for temporary care of children in foster-family homes a number of States are including in their plans for the fiscal year 1948 special projects for temporary care of children in foster-family homes.

The need for services and facilities for temporary boarding care, particularly in rural areas, had been expressed by State public welfare administrators at the four regional conferences on child welfare called by the Children's Bureau in the fall of 1946.

According to the Federal Register for June 11, 1947, "the last sentence of section 203.6 of the regulations relating to Child-Welfare Services (42 CFR, Cum. Supp., 206.6) is amended to read as follows: 'A State shall not expend such funds to pay for the cost of care of children in boarding homes or institutions which provide care for children except, subject to appropriate conditions specified in the State plan, with respect to temporary care in boarding homes or projects for care in such homes for special groups of children to meet particular needs.'"

LIVING COSTS LEAD TO FAMILY DIFFICULTIES

ACCORDING to an interesting survey by the Family Service Association of America, the pressure of high living costs has been responsible for an increase in America's family troubles, which still reflect the upsets and strains of the war years.

From reports of 114 of its member-agencies in cities from coast to coast, the F.S.A.A. reports that high prices not only are presenting millions of families with the severe difficulty of making ends meet but, directly or indirectly, are contributing to the frequency of marital friction, separation, divorce, and the insecurity of children.

The kinds of problems being brought by parents and breadwinners to family agencies at present indicate that inflation, like depression, seriously undermines the stability of home life. "The effects of abnormal phases in the economic cycles, however, cannot be measured in terms of current statistics," the F.S.A.A. reports. "Children growing up in an atmosphere of frustration and uncertainty in one generation tend to carry over the same instability in home life to the next. Family difficulties, therefore, are not only increasing at the moment but still more are being sown for a future time."

Of the 114 family service agencies in the F.S.A.A. membership included in the survey and located in every principal city of the country, 96, or 84 per cent, found that the rise in living costs had increased the amount of problems brought to them for help in recent months.

Families in the lower-income brackets are the most affected. Inflated living costs were generally seen as creating or aggravating tensions between members of marginal-income families by 84 per cent of the reporting agencies. Yet families in better circumstances are also affected. More than half the agencies said that the "pinch of living costs" was responsible for increased difficulties among families in the higher economic levels.

Although the giving of relief funds has become primarily the responsibility of public welfare departments of state and local governments, the privately supported family service agencies noticed a strong trend among small-income families, not eligible for public assistance, to ask their help in supplementing modest budgets which no longer can cover family necessities. Almost three-fourths of the agencies (82) reported increases in requests for this type of aid to help cover food, clothing, rent, emergency health needs, and other family essentials.

Even where incapacitated families are obtaining financial assistance from public agencies, the family service agencies found a sizable flow of applications from families who claim that relief grants are too small, in view of present prices, to keep their families going. Nearly half the family service agencies noted a recent gain in such applications. In some cities and states the situation of these families has been made more desperate by an actual lowering of relief standards in recent months, making fewer people eligible for public assistance.

Where, some months ago, many families managed to buy their minimum needs in food, clothing, shelter, and still to pay the doctor, the survey showed that, increasingly, lower-income families have not enough money to pay for essential health care. This is reflected in the report by 60 per cent of the agencies of increased requests for assistance in meeting medical expenses.

Another indication of family troubles is an apparent increase, in many sections of the country, of the number of mothers who are finding it necessary to take jobs to bolster the family earnings. A total of fifty, or 43 per cent of the agencies, observed an increase in the number of working mothers; and about an equal number of agencies observed a gain in the number of mothers, already at work, who no longer found it possible to afford adequate care and supervision of their children while they were away from home. Nearly a fourth of the agencies traces this inability to provide adequate care for children of working mothers to an increase in the number of "problem children" brought to them for help.

Social workers in the family service agencies detected many other ways in which high prices are affecting family stability. They mentioned most frequently the inability of families to find adequate housing, not simply because of the shortage of housing space but because small wage-earners could not afford the rents even when space became available. They also cited frequently the number of families asking help and advice because they had exhausted savings, gone heavily into debt, or overextended themselves in instalment buying.

Other important evidences of home-finance difficulties observed by the agency workers included inability to afford replacements in broken household equipment, which increases family labor and hardship; children leaving high school to help support families; families hard pressed to buy adequate food and unable to meet special diet needs; less use of recreational resources costing money; more marital friction—husbands do not understand why wives cannot manage family funds; general feeling of hopelessness about lowered standards of living; children kept out of school because of lack of proper clothing; postponement of needed medical and dental care; and families unable to continue support of aged or sick relatives.

The family service agencies surveyed appeared to be in general agreement that the largest proportion of the families under pressure because of the inflationary movement were not at this point in the process of breakup and failure. As one family service society put it: "For some families, the necessity to find ways of stretching their income has been a rallying point for the family to work together." On the other hand, in families where there is already instability and discord, high living costs are frequently providing the "last straw" in family breakdown.

City by city, the reports of family service agencies indicate that the family troubles stimulated by high prices often represent acute distress and are often widespread.

RELIEF CLIENTS ARE AGAIN MOVED ON

THE war years of good wages and work for all ended the scandal of moving relief clients on to other states. But the old poor law policy of "moving on" is not forgotten. Not long ago Los Angeles was again found moving a family of former "Okies," with their eleven children who had acquired settlement in California, back to the state of Oklahoma. During the depression years the "moving on" of clients was so common that it was not news. But this is "news" today, and a magazine like the *Nation* takes note of it. The *Nation*'s account of the new old policy is as follows:

> Loading the thirteen members of the B—— family into a 1931-model car, Los Angeles County officials recently started the clan on the long road back to Bartlesville, Oklahoma. For weeks Ma B—— had held out against returning to Oklahoma, for the family, after five years' sojourn, had acquired legal residence in California. But the county officials, with a vast experience in such cases, finally "induced" the B——s to leave with the promise of four new tires and tubes, a new battery, a tail light, and a connecting rod for the jalopy. With characteristic canniness, the officials refused to give the B——s a lump sum for expenses en route, but arranged that they should receive small stipends from other welfare agencies along the line of march. No sooner had the B——s arrived in Oklahoma than the welfare officials there disclaimed responsibility, on the ground, of course, that the B——s were now legal residents of California. At last report the B——s were headed westward again on Highway 66, made famous in "The Grapes of Wrath." The first case of its kind to occur since the war, the B—— story was treated in the Los Angeles press in a manner calculated to serve notice that the lush days of wartime prosperity were over. Somewhat out of practice in the fine art of shuffling relief cases back and forth across state lines, the Los Angeles welfare officials are obviously preparing for the period of stress and strain that lies ahead. Let future historians note the saga of the B——s and their eleven children as the first adumbration of the "hard times" of 19——!

A DISGRACE TO CHICAGO

A LARGE majority of the men and women arrested and sent to so-called "lockups" pending a court hearing should not be penalized, since they have not been found guilty of any offense. But the story of the Chicago lockups recently told very graphically by the John Howard Association shows dire conditions in the lockups.

The Howard Association's report[1] shows that Chicago's thirty-seven police lockups, at least eleven of which are more than fifty years old, are "cesspools of disease and filth" and are evidence of "dereliction of duty on the part of the commissioners of police, health, and fire departments." Of the "active city lockups," the study shows that twenty-five are "infested by rats and other vermin" and are "an affront to the dignity of the thousands of innocent human beings who are detained unnecessarily." In twenty stations men sleep on wooden benches, in thirteen on metal slabs. The detained men are kept in cells where the fight against vermin was long ago given up, where inadequate lighting, miserable food, overcrowding, prevail—which on week ends make several stations "resemble the infamous Black Hole of Calcutta"—one station held ninety-nine men in its six cells.

Five stations have their lockups in basements in violation of the Chicago Municipal Code.

At one of its regular meetings after the report had been given publicity in the Chicago newspapers, the City Council passed the following resolution:

> WHEREAS, The John Howard Association has released a report of its investigation of the lockups in the police stations of the City of Chicago which reveals that the accommodations in these lockups are unfit for human beings, lack elementary sanitary and toilet facilities, are filthy, verminous, breeding places for disease and are shockingly overcrowded; and

[1] The executive secretary of the association, Mr. Eugene S. Zemans, who was responsible for the study, offers a free copy of the report to any reader of the *Review* who will send ten cents to cover mailing (608 South Dearborn Street, Chicago 5).

WHEREAS, A great city like Chicago owes a humanitarian duty to its citizens to provide clean, sanitary places of confinement for persons who may be arrested, especially since it is a matter of record that many who are arrested are found not guilty by the courts and ordered discharged; and

WHEREAS, The overcrowding in the lockups is due in a large measure to the neglect of the municipal court of Chicago to assign a judge to hold night court sessions to give persons arrested a prompt hearing and arrange for their release on bond;

Now, Therefore, Be It Resolved, That a copy of the report of the John Howard Association be sent to the Commissioners of Police, Health and Buildings with directions (*a*) that they and each of them take prompt steps to correct and eliminate evils therein disclosed, and (*b*) that they shall submit to this Council within sixty days a program for the permanent improvement of the lockups from the standpoint of structural improvement, sanitation and comfort;

. . . . That the Municipal Court . . . . be requested to assign one or more of the associate judges of said court to hold court each and every evening during the week, Sundays excluded, to hear cases involving arrests of persons to the end that the cases may be promptly disposed of or the defendant speedily admitted to bail and released from custody.

NOTES FROM THE PROFESSIONAL SCHOOLS

THE secretary of the American Association of Schools of Social Work announces two new professional staff members to assist in carrying the expanding work of the Association: Miss Joan Kain, as assistant executive secretary, and Miss Elizabeth Lloyd, who replaces Miss Mossman as consultant on professional education. Miss Kain, who has recently been with U.N.R.R.A., will work with the program committee in planning the annual meeting to be held in Minneapolis in January; and will also give staff service to several other committees, including the Committee on International Social Welfare Co-operation. Miss Lloyd has been assistant professor of public welfare in the Loyola University School of Social Work in Chicago and has also served as a public assistance analyst with the Social Security Board.

The Association has received a grant of $5,000 from the United States Public Health Service from funds made available under the National Mental Health Act. This grant will be used for the provision of increased field services directed toward the strengthening of the smaller schools, the development of authoritative data and criteria for block field work plans, the promotion of better teaching of the basic psychiatry courses for all social work students, and the development of materials to assist the schools of social work in determining what may be offered in the third graduate year.

With regard to developments in new schools of social work, the Association reports that an accrediting study has been made at the University of Kansas School of Social Work; that the University of Missouri Department of Social Work has been accepted for study; and that an application for membership which has been received from the University of Manitoba School of Social Work will be presented to the Accrediting Committee at its next meeting.

The University of Denver School of Social Work has announced that Dr. Emil M. Sunley has been appointed director. Professor Mark Hale, formerly of the Tulane School of Social Work faculty, has been appointed chairman of the Department of Social Work, University of Missouri. The Loyola University School of Social Work has appointed Dr. Matthew N. Schoenbaum dean. Miss Julie Grenier has been made acting director of Our Lady of the Lake Graduate School of Social Service. Mr. A. A. Smick has been made acting director of the State College of Washington Graduate School of Social Work. The appointment of Dean Leonard Mayo as vice-president of Western Reserve University means, unfortunately, that a new dean must probably be found for the School of Applied Social Sciences. In the Toronto School of Social Work, Alan F. Klein has been appointed assistant professor of social work to

succeed Mr. Gold in charge of the school's specialized program in group work and recreation. Dr. Susanne Schulze has been appointed professor of child welfare at the School of Social Work of the University of Connecticut.

The Board of Directors has approved the Association's renewing its membership with the International Committee of Schools of Social Work, of which Dr. Réné Sand is chairman and in which the Association holds a corporate membership.

The case materials, prepared by the Subcommittee on the Preparation of Case Work Training Materials, may be obtained from the office of the Association for a small charge.

The American Association of Medical Social Workers announces that Miss Mary Blanche Moss has been appointed executive secretary of the Association. The Association has accredited the programs offered in the Boston College School of Social Work, the Kent School of Social Work at the University of Louisville, the Boston University School of Social Work, and Howard University Graduate School of Social Work.

Through a grant received from the Commonwealth Fund, Miss Madeline Lay has been appointed educational secretary of the American Association of Psychiatric Social Workers.

The Institute of International Education has recently issued a *Handbook of Fellowship, Scholarship and Study Grant Opportunities in the United States for Students from Devastated Countries*, which is available from the office of the institute, 2 West Forty-fifth Street, New York.

The Veterans Administration has announced that a total of 1,321 disabled veterans are in training for social work under the Vocational Rehabilitation Act (Public Law 16). This figure was reached in a 79 per cent sampling of the records of some 229,000 handicapped ex-servicemen and -women in schools and on-the-job training courses on May 1. Veterans with service-connected disabilities are eligible for education and training under Public Law 16, if they require such training to restore their employability. The length of education depends upon the time needed to complete the course and become employable, although the maximum is four years except in special cases. While a veteran is in training, and for two months after his employability has been determined, he will receive a subsistence allowance from V.A. in addition to his disability compensation.

Last summer the New York School of Social Work completed its fiftieth summer session, and the school issued a brief bulletin which reviewed the record of half a century of our oldest school of social welfare. The *Review* is glad to congratulate the New York School on its notable anniversay and to quote a few paragraphs from its bulletin:

> The first faint straws in the wind suggesting the possibility of social work emerging as a distinct profession, with its own educational discipline, could be seen by a discerning eye fifty years ago. After repeated requests were granted for lectures and in-service training, the Charity Organization Society at that time organized the first training course in the social work field —a summer institute of six weeks' duration. The need for some preparation in this work with other human beings was so widely felt—with students in the very first "course" coming from 14 colleges and 17 states—that the Society found itself unable to satisfy the demand by its summer course alone. In 1904 it developed a full year's curriculum, with the designation of "New York School of Philanthropy." Eight years later it expanded into a two-year program and in 1919, the School became known by its present name "The New York School of Social Work." The School has through the years continued under the auspices of the Society and today is governed by a Committee of the Board of the Community Service Society, which was in 1939 formed by the merger of COS and AICP.
>
> The direction in which the School would grow was foreshadowed in a letter dated November 15, 1904, in which Mr. John S. Kennedy wrote Mr. Robert W. de Forest, President of the Charity Organization Society, offering funds for the expansion of the summer courses into a two-semester school. In this letter he expressed his hope that the School would affiliate with Columbia University and other educational institutions. He named as ex officio members of

the Committee on Philanthropic Education the presidents of the "more important societies dealing directly with the poor," and emphasized his desire "that this School shall give a training in the practice of that broad charity which is free from any limitations of creed or nationality. . . . .

In 1940 the School officially became part of Columbia University, climaxing the development heralded by Mr. Kennedy. . . . . The School still maintains its administrative and financial autonomy under a committee appointed by the Community Service Society. In its educational program it is an integral part of the University. Policies of the University are followed in the admission of students, appointment of teaching staff, and awarding of degrees.

NEW WELFARE MONOGRAPHS

THE *Review* has not been able to review most of the interesting pamphlet materials which have recently been received. Some of these, therefore, we are listing here for the benefit of our readers. One of them, a sixty-four-page pamphlet, *The Immigration Laws of the United States: An Outline*, by Albert E. Reitzel, the assistant general counsel of the United States Immigration and Naturalization Service, who was for many years assistant solicitor for the Department of Labor, may be obtained from the *Virginia Law Review*, Charlottesville, Virginia, from which it was reprinted (price, $1.00). The pamphlet gives a readable picture of our immigration laws for the layman as well as for the lawyer. Two other immigration pamphlets, published by the National Committee on Immigration, New York, are *Economic Aspects of Immigration* (63 pp., $0.20) and *Immigration and Population Policy* (56 pp., $0.25).

Then, there is the useful *Housemother's Guide*, by Edith M. Stern in collaboration with Howard W. Hopkirk (New York: Commonwealth Fund, 91 pp., $0.50). Other substantial publications include *Group Work—Case Work Cooperation: A Symposium*, sponsored by the American Association of Group Workers (New York: Association Press, 49 pp., $0.50); a useful publication by the National Travelers Aid Association on *Volunteers in Social Service*, by Dorothy H. Sills (New York, 51 pp., $0.30); and three publications by the Woman's Press, New York: *Teen Canteens—Some Special Problems*, by Hazel Osborn (47 pp., $0.50); *"Pennies for Health,"* by Clara A. Hardin (30 pp., $0.25); and *Community Wise*, compiled by Edna H. Porter (64 pp., $0.75). Two publications of the Family Service Association of America, New York, are *Short-Term Therapy in an Authoritative Setting*, by Bertram M. Beck (112 pp., $1.25), and *Developing Insight in Initial Interviews*, by Alice L. Voiland, Martha L. Gundelach, and Mildred Corner (54 pp., $0.60). *Scheduled Salaries for Social Work Positions in Hospitals in New York City, December, 1946*, is by Ralph G. Hurlin (New York: Russell Sage Foundation, 42 pp., $0.40). A recent *Social Security Reading List*, by Robert M. Ball, "provides material on the history of the social security movement, a description of the programs and how they operate, foreign experience, the background of the most significant problems to be dealt with, and a sampling of conflicting points of view among social security experts" (Washington, D.C.: American Council on Education, 40 pp., $0.50). Others are a publication sponsored by the American Council on Education and the National Social Welfare Assembly, *A Report of the Committee on a Federal Department of Health, Education, and Security* (Washington, D.C., 58 pp., $0.50); *A Study of the Income Procedures of National Membership Organizations: Child Welfare League of America, Inc., Community Chests and Councils, Inc., Family Service Association of America, etc.* (New York: National Social Welfare Assembly, 53 pp., $1.00); *Day Care Centers for School Children: Planning and Administration*, by Clara M. Allen (New York: Child Welfare League of America, 80 pp., $1.00); *Rheumatic Fever, Childhood's Greatest Enemy*, by Herbert Yahraes (New York: Public Affairs Committee, Inc., 31 pp., $0.10); *Third Annual Report of the Youth House: April 1, 1946 to March 31, 1947* (New York, 22 pp.); *Annual Reports: How To Plan and Write Them*, by Beatrice

K. Tolleris (New York: National Publicity Council, 39 pp., $1.00); and *Adventures in the Realm of Ideas*, by Victor S. Yarros (Girard, Kan.: Haldeman-Julius Publications, 76 pp., $0.25).

THE GRACE ABBOTT FELLOWSHIP IN PUBLIC WELFARE

ANNOUNCEMENT FOR 1948–49

A PUBLIC welfare fellowship of one thousand dollars for the academic year 1948–49 is again offered by the national Delta Gamma fraternity in honor of the public services of Grace Abbott, who was a member of Delta Gamma when she was a student at the University of Nebraska.

This fellowship is open to any woman graduate of an accredited American college or university and may be used at any approved school of social work; but preference will be given to candidates who have been employed in the public welfare service and who plan to return to the public service. The fellowship will be awarded in May, 1948, by a committee of Delta Gamma alumnae, including Mrs. Arthur H. Vandenberg, of Washington, D.C., and Grand Rapids, Michigan, honorary chairman; Mrs. George Bowerman, The Ontario, Washington, D.C., chairman; Miss Blanche Garten, Lincoln, Nebraska, secretary; Mrs. E. Tiel Smith, ex-officio, president of Delta Gamma, Philadelphia, Pennsylvania; Edith Abbott, the University of Chicago; Mrs. Ruth Bryan Rohde, Ossining, New York; and Mrs. Payson Treat, Palo Alto, California. Miss Mildred Arnold, of the United States Children's Bureau, and Miss Agnes Van Driel, of the Public Assistance Bureau of the Federal Security Agency, will again serve as consultants for the committee in making the award for 1948–49. Applications should be filed not later than April 1, 1948. Applicants who filed before may wish to apply again.

Application blanks may be obtained after January 1, 1948, from the secretary of the committee: Miss Blanche Garten, 1827 A Street, Lincoln 2, Nebraska.

IN MEMORIAM

HOWARD R. KNIGHT
1889–1947

NEWS of the sudden death of Howard R. Knight from a heart attack came as a great shock to his many friends in this country and abroad. Howard Knight had been general secretary of the National Conference of Social Work ever since 1926 and was well known to most of the social workers in this country. Before his long association with the National Conference began, he had been secretary of the Ohio Welfare Conference. He had also been a staff member of the Russell Sage Foundation and had been acting manager of the insular division of the American Red Cross.

Born in Boston, he was a graduate of Boston University, but he had lived for many years in Columbus, Ohio, which he had made the headquarters of the National Conference. The loss of his two splendid sons, who fell in action during the last war, was one of the tragedies of a tragic period.

Howard Knight had necessarily been closely identified with the International Conference of Social Work, and he had represented our American Conference in connection with the International Conferences held in Paris in 1928, in Frankfurt in 1932, and in London in 1936. For the past year he had been secretary-general of the International Conference, and only a short time before his death he had returned from a meeting of the executive committee in Europe, where plans were being made for the important meetings to be held in Atlantic City next spring.

Howard Knight had for so long been an unusually successful and faithful organizer of our conferences that it is difficult to face the future without him. He was a wonderful program-maker, and large numbers of us remember the great satisfaction wich which he watched the opening program year after year. He will be greatly missed by a host of friends and fellow-workers.

T. ARNOLD HILL, 1889–1947

NEWS of the death of T. Arnold Hill, who was with the National Urban League from 1914 to 1940 and was a leader in social work for more than thirty years, was received with deep regret in many parts of the country.

Born in Richmond, Virginia, and a graduate of Virginia Union University in 1911, he went to New York in 1914 to serve as assistant to the executive secretary of the National Urban League, and he continued his connection with the league for the next thirty years. In 1917 he came to Chicago as western field secretary of the national organization and executive secretary of the Chicago Urban League. When the national league organized its department of industrial relations, he returned to New York to become its director and served until his resignation; he served also for several years as acting executive secretary of the national organization.

During the depression Arnold Hill was a member of the President's Conference on Home Building and Home Ownership, the National Conference on Fundamental Problems in the Education of Negroes, and the New York Governor's Commission on Unemployment Relief. He served also on the industrial relations panel of the New York State Board of Mediation. He had been associated with Fisk University.

Arnold Hill was a member of the New York State Board of Social Welfare from 1936 to 1946 and was active in other state and national welfare groups. Recently he had been chairman of the Southwest Harlem Neighborhood Council and had urged the rebuilding of the area bounded by 110th Street and 125th Street between Fifth Avenue and Morningside Park. He called for "an end to Harlem as a place for Negroes alone."

Among various federal posts he held were those of examiner and special agent for the United States Employment Service, consultant to W.P.A. in 1938 and 1939, assistant director of the Office of Negro Affairs of the N.Y.A. from 1940 to 1942, and special assistant to the O.P.A. from 1942 to 1945.

He was an active member of the A.A.S.W. and a well-known figure at the National Conference of Social Work, where he had many long-time friends, and he was a member of the executive committee of the New York State Conference of Social Work.

DR. JAMES STUART PLANT 1890–1947

A LEADING child psychiatrist, Dr. Plant was known to large numbers of social workers as an authority in his field, and his death at the early age of fifty-seven is a national loss. Dr. Plant was psychiatrist for the Judge Baker Foundation in 1922–23, but in 1923 he became director of the Essex County Juvenile Clinic in Newark, New Jersey, which is one of the oldest tax-supported psychiatric clinics in the United States. To it are referred children brought into juvenile court as well as problem cases handled by state, city, and private agencies. Dr. Plant's study of causes and his recommendations became so well known that parents, too, went voluntarily to seek his advice.

Born in Minneapolis, Dr. Plant was graduated from Hamilton College and received his medical degree from the University of Pennsylvania, studying later at Cornell and Harvard and at the Sorbonne in Paris.

Dr. Plant was chairman of the National Committee for Mental Hygiene and had conducted courses in child psychology at Rutgers, Yale, Columbia, and New York University. His book, *Personality and the Cultural Pattern*, is widely used as a text.

Social workers also knew Dr. Plant for his interest in the early development of visiting-teacher work and other services for children.

BOOK REVIEWS

Adopting a Child. By FRANCES LOCKRIDGE with the assistance of SOPHIE VAN S. THEIS. New York: Greenberg, 1947. Pp. vi+216. $3.00.

Adopting a Child, written for persons who desire a child, is the result of the collaboration of Frances Lockridge, a feature writer, and Sophie van S. Theis, a professional social worker, who is secretary of the Child Placing and Adoption Agency of the New York State Charities Aid Association. It is well written and interesting. Miss Lockridge has apparently utilized agency records with skill, for she has made abundant use of the case narratives with which agency records are always well provided. The book is written from the agency standpoint and quite rightly points out some of the advantages of adoptions planned by an agency and their attempts to fit the child to the foster-home.

Many of the questions raised by the general public as well as by persons seeking a child to adopt are answered, but unfortunately no mention is made of the difficulties incurred in placement of a child outside the state where the agency is located.

One chapter is devoted to the child of unmarried parents. The agency's part in helping the mother to arrive at a final decision for the child's placement will be of interest to persons trying to develop satisfactory plans for mother and child. The fact that adoption through an agency rarely results in complications arising from a change of heart and in a request for the return of the child should encourage prospective foster-parents to use an agency rather than other resources to obtain a child for adoption.

Another chapter and also occasional references throughout the book discuss examinations and tests. The use of developmental tests for young infants is described, and it is explained that a valid estimate of a child's development may be obtained for a child as young as three months. A simple explanation of these tests is given to illustrate their help in arriving at an evaluation and the reliability of infant tests.

The probationary period, which provides an opportunity for the placing agency to watch the adjustment of the child and the foster-parents to each other and leads up to the final consent to adoption, is a real advantage to the child. Strangely enough no mention is made of the great advantage of agency placement in that it may help to prevent a child from being forgotten through the years so that he is never legally adopted. Fortunately, an agency feels a great responsibility for protecting the child and will take particular pains to see that the final adoption is consummated.

Some of the elements in successful adoptions are described, and the intelligent processes followed by agency workers cannot help but provide security to prospective foster-parents.

The chapter on case-recording of adoptions includes six descriptions of successful placements as well as two of unsuccessful placements which show patient, sympathetic treatment always with intelligent understanding of the points that were responsible for the failure of the child to fit into the home.

In the chapter on the adoptive parents as well as elsewhere in the book the question of telling the child of his adoption is brought up as well as that of answering his questions about his own family. The infrequent use of abrogations occasionally resorted to when the child has proved seriously delinquent or so feeble-minded that the foster-parents cannot afford the expensive care he needs is also discussed. The dissolution of the foster-parents' marriage or the return of the child to his natural parents may also result in abrogation.

One of the last chapters in the book contains excerpts from letters of parents and children, which give us a very good picture of the mutual satisfactions enjoyed.

In the opinion of the reviewer the chapter on laws governing adoption is the weakest chapter in the book, for it simply recites some of the points of the adoption laws of the various states with little or no interpretation of their advantages or limitations. The essentials of adoption law and procedure prepared by the United States Children's Bureau likewise is quoted without comment.

In the Appendix is found a helpful list of adoption agencies given by states, but no discussion is made of the wide divergence of resources in individual states. It seems unlikely that Indiana, Massachusetts, Pennsylvania,

and Tennessee have no child-placing agencies except the state department of welfare, yet no explanation is made of this. In Michigan and Ohio, the two states with the largest number of child-placing agencies, we find thirty-five and thirty-six agencies, respectively, in addition to the state department. Undoubtedly many of these agencies place relatively few children, and numbers give little evidence of the value of the placements made. Fortunately it is suggested that persons write the department of welfare in the state in which they are interested so that they may receive more specific information about the placement policies of individual agencies.

A limited bibliography is included as well as samples of an application blank prepared and issued by the Child Welfare League of America. Altogether the book is a most helpful one, which gives us detailed information on present-day adoption procedures.

MARY RUTH COLBY
Minneapolis, Minnesota

Medicine in Industry. By BERNHARD J. STERN. New York: Commonwealth Fund, 1946. Pp. xv+209. $1.50.

This little volume, like others in the series of twelve studies sponsored by the New York Academy of Medicine Committee on Medicine and the Changing Order, is concerned with varied aspects of medical care in our rapidly changing society. Like the others this study assembles and interprets hitherto scattered and little-known materials concerning current medical and health problems in industry. Although the title would suggest a study concerned with industrial medicine, the author, a sociologist, attacks the subject from the social, economic, and organization side. His findings should stir the reader to a righteous indignation over the colossal failure of this country either to provide suitable safeguards to the industrial worker's health while he is at work or to develop anything like effective services to restore him after he has been disabled by disease or injury arising from the conditions of his employment.

While some progress is being made in the provision of safer and more healthful working conditions, the author makes it clear that advances in our knowledge of the causes and cures of some industrial diseases and how to prevent them and in the organization for and provision of necessary medical treatment to those who suffer from industrial diseases and injuries are painfully slow. Shocked by the casualties suffered by our armed forces during the recent war, we remain strangely apathetic over the very great casualties suffered by workers in industry during the four war years, 1942–45. More than ten million persons suffered industrial injuries during those four years, of which approximately eighty thousand were fatal and almost half a million resulted in permanent disabilities. In addition, an undetermined number of workers were disabled and killed by a variety of diseases contracted while working in dusty mills or mines or while handling and working with a variety of poisonous substances. A very considerable number of these casualties could have been prevented or cured if the American public had been as determined to protect the industrial army as it was to protect and care for its combat army. We are all grateful that the military losses ceased after what seemed at the time to be an interminable four years, but few of us seem to be shocked over the industrial losses which began long before 1942 and which still go on inexorably year after year.

The painfully slow development of industrial safety programs, workmen's compensation legislation, and other measures designed to protect our industrial force are reviewed. Although workmen's compensation legislation and factory inspection acts were theoretically won many years ago, the coverage of industrial accident insurance still extends to only about 40 per cent of our working force, and factory inspection continued to be largely ineffective. In 1940 the federal and state governments spent a paltry $4,681,000 for industrial health programs, including such services as inspection of factories for sanitation and safety, inspection of mines, regulation of working conditions, and industrial hygiene programs. This represented less than ten cents per worker for the country, and it varied from one-half a cent per worker for the year in Mississippi to forty-eight cents in West Virginia.

It is discouraging to learn that a negligible amount of research in industrial medicine is in progress. Although industry is pouring millions into research in developing new products, it is doing almost nothing to discover causes and treatment of industrial diseases as such. The most significant work in this field is being done by the United States Public Health Service.

The organization of medical services in in-

dustry remains spotty and generally inadequate. In 1942, according to a report of the American Medical Association and the Procurement and Assignment Service, there were only 2,300 full-time salaried physicians engaged in industrial medicine. Several concerns have organized special medical services for their employees, but, for the most part, the industrial worker must obtain his medical care from a private physician. The medical profession itself has generally disparaged the industrial physician, regarding him as a "case finder" for the private doctor instead of a therapist. The author says:

> . . . . The attitude of the organized medical profession has been to consider the work of the industrial physicians as limited to the treatment of injuries and diseases in the plant. Any other medical service is considered as interference with the rights and as an encroachment upon the province of physicians in private practice. If the diseases are non-occupational, the duty of the industrial physician is regarded as discharged when he has reported his findings to the worker involved. The industrial physician is considered to be overstepping his duties as plant physician if the treatment he renders in the case of non-occupational diseases goes beyond care adequate for the relief of an emergency condition or to make it possible for the employee to finish his shift.

The medical schools are said to be doing little to train physicians to undertake needed work in industrial medicine. In 1944 only five medical schools offered special courses in industrial hygiene or industrial medicine and surgery, and in 1941 fifty-two schools offered an average of 6.7 hours of instruction in industrial health.

Although the available facts about the development and the current status of industrial medicine are presented in this volume, no recommendations are made about what should be done to correct the serious deficiencies. However, it is doubtful whether any very effective program of industrial medicine will be provided until the nation moves ahead with a comprehensive medical and health program for all the people. The conclusion seems to be indisputable that industry and private medicine have failed miserably to meet the demands in industrial medicine. It would appear that an adequate program of industrial medicine, as is true of a general medical and health program, can be developed only with a considerable measure of government sponsorship and finance.

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Society's Stake in the Offender: Yearbook, National Probation Association, 1946. Edited by MARJORIE BELL. New York, 1947. Pp. 291. Cloth, $1.75; paper, $1.25.

After a wartime lapse of one year the National Probation Association resumed its annual conference in 1946, meeting in Buffalo as an affiliated group with the National Conference of Social Work. This volume is composed chiefly of papers delivered at the Buffalo Conference, a legislative digest, and miscellaneous reports of the Association.

As usual, the papers have been organized into topical sections, increasing their reference value for students of probation, parole, and penology. In Section I, "Looking Backward and Forward," the contributors are Charles L. Chute, executive director of the Association, and Dean Emeritus Roscoe Pound, of the Harvard Law School. Mr. Chute describes in a brief but interesting paper the early struggle and growing vigor of the Association, now in its twenty-fifth year, as a force to promote intelligent and understanding treatment of those who have been declared in conflict with the law. Dean Pound points out succinctly but comprehensively the need for adequate personnel and sound administration in the modern court of socialized justice. We think we have traveled far since the infancy of the National Probation Association, but the journey is only well under way.

Edwin J. Lukas, Saul Alinsky, and Walter M. Berry have written stimulating papers for Section II, "The Community's Job in Crime Prevention." Lukas sketches the unpalatable history of the weirdly assorted nostrums that have passed for delinquency and crime prevention. Alinsky shows that much of today's effort also fails to stand the test of close, objective scrutiny. These men realize that true prevention is possible only when the many broad causes of individual and social insecurity and maladjustment are successfully opposed. Berry outlines the ambitious, carefully planned state and local program of service to youth undertaken in the state of Michigan, where efforts to practice what is preached on youth adjustment have been notable over the last decade.

Section III, "Making Delinquents," presents case histories by Irene Kawin to illustrate the increasingly well-known relationship between family conflict and delinquency. Racial antagonism and the formidable barriers that it creates are described clearly by Robert L. Cooper. To deal effectively with these rock-ribbed foun-

dations of the many-sided causal pattern would indeed be an approach to delinquency prevention, though it doubtless holds slight appeal for those who still think the job can be done by building a playground or by jailing problem parents.

The scandalous lack of adequate detention and treatment facilities for children and youth awaiting court appearance is vividly narrated by Sherwood Norman and by Edgar M. Gerlach in Section IV, "Detention, Juvenile and Adult." Gerlach, a federal prison inspector, gives a clear account of the nauseating conditions tolerated in too many local jails, where adolescents frequently are held in association with the most depraved adults. As the author wearily asserts, these are not new revelations. A widespread, unyielding attack upon these anachronisms in community after community, from coast to coast, may be reported in the annals of tomorrow. But does tomorrow ever come?

Section V, "Techniques of Treatment," comprises five papers. Karl Holton explains the ambitious program of the California Youth Authority, which derives its power from a statute varying in certain important details from the model act indorsed by the American Law Institute. Richard A. Chappell, the federal probation chief who rendered such splendid service in the Navy as a specialist in the treatment of wartime offenders, summarizes his experiences with this group during the war and after. He recommends that the veteran be understood but not pampered and protected from the responsibilities of everyday living. He expects the veteran to encounter many problems in adjusting to civilian life but believes that "in the main he will prove himself to be a good and useful citizen." Florine J. Ellis concerns herself with the treatment of sex delinquents. She points out that rare insight, skilled individual treatment, directed group therapy, and interagency cooperation are essential to a successful program for this group. Two United States probation and parole officers, Edwin B. Zeigler and Charles H. Z. Meyer, have contributed practical material for the court social worker. Zeigler has written on presentence and preparole investigations, while Meyer's paper is entitled "How Do Probationers and Parolees Differ?" Those who have worked with both groups will tend to agree that "probation and parole are like two oak leaves, very similar but not identical." Meyer analyzes the similarities and the differences.

Fred J. Murphy and John Otto Reinemann are the contributors to Section VI, "Delinquency Off the Record." Murphy makes statistical comparisons of unofficial and official, or court-recognized, delinquency, based on actual studies. He concludes that our failure to make intelligent use of the courts encourages many children and youth to persist in antisocial conduct until they have become confirmed offenders. Reinemann offers constructive suggestions for research activities in the field of probation. He considers no probation department too small for this type of objective self-examination. In logical sequence the next section follows, with the paper read by William Shands Meacham, on "Probation and Parole in the Public View." He sees no reason why these forms of social treatment need always receive unfavorable publicity, emphasizing their failures. He believes the average American will receive with sympathetic interest stories of successful adjustment on probation and parole. "More, he will be glad to do what he can to help the man who is on the way back toward good citizenship."

The 1946 *Yearbook* takes its place as one of the best. Some of the papers are shorter than usual, but there is an encouraging willingness to face facts with reasonable frankness. Much is still unknown about delinquency, crime, and their treatment, but at least we are helped by this volume to see that we can go much farther in applying the knowledge already gained.

RICHARD EDDY

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New Day Ascending. By FRED L. BROWNLEE. Boston: Pilgrim Press, 1946. Pp. 310. $3.00.

The American Missionary Association celebrated its one hundredth anniversary in 1946. Throughout the first century of its existence it was the champion of minority groups, striving to eliminate race prejudice and to secure for them justice and a better way of life. According to Mr. Brownlee, the author of *New Day Ascending* and for the last twenty-six years the Association's executive secretary, the "second-century activities" will have the same objectives, but the methods for attaining them will be somewhat altered to conform with current trends.

This volume reviews the more important phases of the Association's work in the past. The lion's share of the book is given to an account of work undertaken in behalf of American Negroes, perhaps because the Association was founded in 1846 by a number of antislavery organizations which, having realized the value of concerted effort, decided to combine and to continue as the American Missionary Association. An interesting chapter deals with one of these founding agencies, the Amistad Committee, and with the successful campaign it conducted in behalf of a group of Negroes who had been brought to trial in New Haven on the charge of having mutinied and having killed the captain of the "Amistad," the ship on which they were held captive. Their plight aroused the sympathy of socially minded citizens of New Haven, and through their efforts the Negroes were acquitted and eventually returned to Sierra Leone, West Africa, where they had been kidnapped.

In its work for Negroes the Association has placed chief emphasis on providing educational opportunities, with its first school for them in 1861 in Fortress Monroe. At the peak these schools numbered five hundred. Later they were transferred to local public school authorities or to other qualified agencies as soon as it became advisable, and their number now is greatly decreased. In 1920 the Association was operating fewer than forty educational institutions for Negroes and in 1946 only fourteen, six of them being colleges. The Association has also established credit unions and co-operatives in Negro communities and endeavored in these and other ways to raise their standard of living.

In recent years there has been a shift in approach; much of the work of the Association is now concerned with changing our public's attitude on race issues. "In this there is a deep sense of the inadequacy of institutional services unless individual attitudes also change. In the last analysis the question is one of personal relations." The Association now tries to inspire people to want to solve racial problems in their own communities, for that purpose arranging institutes on racial relations and promoting intercultural projects in schools and elsewhere.

The American Negro is the chief concern of the Association today, but in earlier years it pioneered in services to other minority groups as well, as described briefly in a chapter on "Influential Firsts." They included works among the Eskimos in Alaska, Orientals on the Pacific Coast, Mexicans in our southwest states, American Indians—notably Indians of the Dakota tribe—and Puerto Ricans, as well as activities in foreign countries—in Siam and Jamaica. Gradually these projects have, however, been transferred to other agencies. The Association "has sought always to promote work of a pioneering nature. Whenever other agencies were prepared to carry on as well, or better, they were asked to do so, the Association often furnishing financial aid for several years." The work with non-Negro minority groups may be resumed in the future. A hope is expressed that the association's Department of Race Relations, which was established in 1942, will later include in its program services for Chinese, Japanese, Indians, "and other minority groups which suffer because of class and caste discriminations."

Mr. Brownlee sees progress in the fight against racial prejudice and injustice—hence his book's optimistic title, *New Day Ascending*. There are, however, many obstacles still to be overcome; "liberal education for Negroes on the college level is still missionary work," and Negroes are prevented from voting in several states. On the other hand, the illiteracy rate among Negroes has notably decreased. Their economic situation has improved enormously; "landless, homeless and penniless" in 1865, today Negro Americans own more than ten million acres of farm land; total deposits in Negro banks amounted in 1941 to six and a quarter million dollars. The attitude of the American public toward minority problems has improved noticeably. "College students across America are championing the rights of minority groups. Interracial retreats, as they are called, have become common." The Springfield plan of intercultural education is, Mr. Brownlee thinks, beyond its experimental stage, and Detroit and other cities are at work on similar projects. More than a hundred large cities have race relations committees, some of which have official status with authorized budgets. In addition, a number of other developments are listed which indicate progress in the fight against racial discrimination.

The book is history, well documented and told in vivid, interesting language. Some day a companion volume should be written, making available to the general public material about the Association's "influential firsts," that is, its work with minority groups other than the Negro

group. As the author points out, it was not possible to deal adequately in one book with the many and varied activities of the Association, the archives of which contain a mass of source material with valuable information "about the social, economic, political and religious cross currents from 1846 to 1946."

MARIAN SCHIBSBY

Fillmore, California

A National Labor Policy. By HAROLD W. METZ and MEYER JACOBSTEIN. Washington, D.C.: Brookings Institution, 1947. Pp. 164. $2.25.

This analysis of federal labor policy antedates the Taft-Hartley Act. No mention is made of this or other legislation proposed or passed in the Eightieth Congress. It is for the reader to compare the recommendations of these authors with the changes in policy made by the Congress over a presidential veto in the course of 1947.

The book is divided into three parts. Part I briefly outlines the development of federal policy and the change in the attitude of unions toward government action. In Part II the goals of a sound labor policy are succinctly listed and the criteria to be used in appraising statutory provisions and administrative rulings. In Part III, which includes well over half the book, specific policy recommendations are stated and the argument on which they are based is developed. This section inevitably is in large part a critique of the National Labor Relations Act and the rulings of the Board.

A major thesis of the study is that the overriding purpose of federal policy as it stood at the end of 1946 was the strengthening of the bargaining position of labor and that all issues were resolved by this test. As a result, the position of labor had changed from the less to the more powerful party in collective bargaining. Also as a result, innocent third parties suffered in the bargaining struggles between labor groups as well as in those between management and labor, and the public interest in efficient and uninterrupted production was frequently sacrificed.

The book is so organized and written that no one can be in doubt as to the specific recommendations of the authors. They argue that the government should protect the right of the workers to organize but should refrain from all efforts to promote organization. Obligation to bargain collectively should be imposed on employees as well as employers, and the nature of such an obligation for both parties should be clearly defined by statute. Workers should be permitted to use only the remedies provided by law to enforce union recognition and collective bargaining. Bargaining units should include only the employees of one employer. The authors consider that all forms of union preference in collective agreements should be forbidden, whether the closed shop, union shop, preferential hiring, or maintenance of membership. Work stoppages in violation of a contract or for purposes or by methods contrary to the public interest should lose the protection of the law. Jurisdictional and sympathetic strikes, boycotts and strikes to enforce employment of unnecessary workers, or use of inefficient processes should be placed in the latter category. The offending unions should be liable for damages and their bargaining rights suspended; injunctions should be permissible in such cases and the discharge of workers involved.

Finally, the position is taken that government action to minimize work stoppages should follow only two lines. The basic and most important is that represented by the National Labor Relations Act, removal of causes of stoppages by the definition and protection of the workers' and unions' rights. The second is the establishment of machinery for conciliation and voluntary arbitration. Compulsory arbitration and government intervention in labor disputes are in the authors' opinion unsound and undesirable, economically and politically.

HAZEL KYRK

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The Constitution and Civil Rights. By MILTON R. KONVITCH. New York: Columbia University Press, 1947. Pp. x+254. $3.00.

Here is a much-needed and valuable monograph, the first of its kind, on a phase of "civil rights" that has been overlooked or merely touched upon in papers or articles published in law reviews. Dr. Konvitz has put all sincere advocates of justice and equal opportunity under obligation by this careful and methodical study of the theory and practice, in this country, with respect to the rights of persons to employment, accommodations in common carriers, hotels, restaurants, theaters, etc., without wilful discrimination.

His analyses are based on actual court cases,

and they are masterly. Majority as well as minority, or dissenting, opinions are quoted and considered where necessary, at considerable length. The courts, including the highest, have not always been either consistent or realistic in dealing with statutes and constitutional provisions designed to protect the civil rights of unpopular races or groups, but this, of course, is an old story. In the words of Philosopher Dooley, even the Supreme Court follows election returns. Or, in the less known words of the late Elihu Root, the federal Constitution has been amended more by reinterpretation than by direct legislative and popular action.

The present situation is not a pleasant one to contemplate. In the case of the Negroes, for instance, discrimination is still widespread and notorious. Few of our states have adopted effective fair-employment laws, and in some states the enforcement of these laws leaves not a little to be desired. Congress has been prevented from passing a federal antilynching bill by deliberate and defiant filibustering by southern senators; and the same flagrantly undemocratic weapon will be used again and again, unless public sentiment forces the United States Senate to modernize its antiquated and irrational rules of procedure.

The issues in civil rights cases are often difficult and complex, and the statutes under which they are instituted are not infrequently vague and obscure. The attentive reading of judicial opinions in some of the memorable cases is truly a liberal education in the process of lawmaking and law enforcement.

Lawyers and lay persons earnestly concerned with civil liberties and American ideals and traditions will find Dr. Konvitz' keen study illuminating, interesting, and distinctly sobering. The book should be particularly recommended to southern law schools, attorneys, and sociologists. Some bold preachers, possibly, may find matter for candid sermons in its disclosures.

VICTOR S. YARROS

La Jolla, California

Charles Kingsley and His Ideas. By GUY KENDALL. London: Hutchinson & Co., Ltd., Pp. 190. 21*s*.

The writer of this biography of a celebrated Victorian novelist and social reformer thinks that it is not Kingsley the novelist who will go down to posterity so much as Kingsley the man. Dr. G. M. Trevelyan said in a letter to the author that "Kingsley did a great work in many ways; among others in giving ordinary folk the idea that they could be religious without being ascetic or gloomy or censorious. *In his day* that was a very necessary work. There was more in 'muscular Christianity' than the muscle." Kingsley's works show his desire to bring religion into proper relation with life and to advocate Christian Socialism. The author thinks that much of what Kingsley suggested has been given practical form in the new work of the church to make religion more real and popular. But the Christian Socialists were as a group well in advance of their time.

Kingsley thought that the poor in general were too fatalistic about illness, and in 1848–49 he preached a series of three sermons at Eversley, afterward published under the title *Who Causes Pestilence?* He was unwilling to have such devastating epidemics spoken of as divine visitations, and he emphasized the fact that it lay within the power of men to prevent them. Kingsley opposed having a day of national fasting to avert the pestilence. How was national fasting going to change the many villages where the poor were living in "undrained, stifling hovels, unfit for hogs"? He was delighted when Lord Palmerston refused to proclaim a national fast day.

He was at one time a supporter of woman's suffrage; but, although he joined a committee, organized by John Stuart Mill, for promoting the cause, he later resigned from it on the ground that he did not approve of propaganda conducted on public platforms by women themselves. He warmly supported the movement for the medical education of women, their admission to medical degrees, and their right to practice in the profession.

Charles Kingsley was a social reformer, but this book will be interesting only to social workers who already have an interest in the mid-Victorian period and who are familiar with the problems of the England of the 1840's and 1850's, the England of slums and insanitary village cottages, the England of cholera outbreaks and smallpox, and the sweating system.

Kingsley was a clergyman of the Church of England, and many of the "ideas" here discussed relate to his interpretation of the teaching of the Church of England in his time. There are chapters dealing with the different periods of his life, with Newman and with Darwin, as well as chapters on "The Poet" and "The

Novelist." Kingsley's crusade for sanitary reform is found in various chapters. The discussions of the novels, especially *Yeast*, *Alton Locke*, and *Two Years Ago*, are all connected with the social questions of the time. But the reader who does not bring a knowledge of social conditions of the Kingsley-Maurice period will not find an answer to many of his questions. The days of *Politics for the People* seem very far away from the social questions of today.

E. A.

Tory Radical: The Life of Richard Oastler. By CECIL DRIVER. New York: Oxford University Press, 1946. Pp. ix+597. $5.00.

This is an interesting biography of one of the early leaders in England in the field we now call "labor legislation"—shorter hours, abolition of child labor, safe and sanitary factories. When he was past forty, Oastler learned by accident of some of the serious and cruel consequences of the industrial system—incredibly long hours of work, insanitary conditions, the overwork of women, and the ruthless exploitation of children. After this discovery Oastler became a propagandist for reform, and within a short time he was a national figure fighting with energy, imagination, and courage for a ten-hour law. To his surprise he found that he was accepted as a brilliant orator, a vigorous pamphleteer, and a man with organizing ability to lead a reform movement. He was a dramatic figure who came to exercise great influence over the factory workers of the north of England and to earn for himself the title of "The Factory King." He was also called the "Father of the Poor, the Defense of the Oppressed, the Dread of the Tyrant." Even the London *Times* said that he had been "the providential organ of the oppressed and suffering poor."

The title of the book indicates the conflict in Oastler's life and history. A leader in a radical reform movement, he believed in a new democratic Toryism as a means of saving the people from the effects of industrial capitalism. Like Sadler he was a Tory. He was a "Church and King" man to the end. He believed in the "Tory Democracy" as an operative force in British politics. But to create a new "radical Toryism" was not an easy undertaking.

Oastler is well described as "a born controversialist of considerable power." In 1830 he published his first letter to the *Leeds Mercury* on "Yorkshire Slavery," his protest against children from seven to fourteen years of age working from 6:00 A.M. to 7:00 P.M. His demand that "Yorkshire children shall no more be slaves" was a call to action. His first letter was followed by a second, a third, a fourth, a fifth, and a sixth letter on Yorkshire "slavery." There were those who were sorry that a good cause should have such an "intemperate advocate." To them Oastler was "well meaning but unbalanced," and he was even called an "incendiary."

There is the story of the "rousing of the north," of Sadler's Ten Hours Bill, the excitement of the Reform Bill of 1832, and the new Poor Law of 1834. There is an interesting chapter on "Philanthropy Becomes Politics," which deals not only with the Short Time Committees but with Oastler's later letters on "Yorkshire Slavery."

To the "factory workers and hand loom weavers who flocked in their thousands to hear him," Oastler's speeches were a promise of the future—of the things that must come. Oastler denounced not only long hours but other objectionable and harmful conditions in the mills—brutality—"cruelties which had grown common with the spread of unsupervised child labor."

Oastler's crusade was turbulent, bringing him into contact with numerous older labor leaders as odd and striking as himself. He provoked riots and fisticuffs; he went bankrupt and was in a debtors' prison for more than three years, first in the Fleet, where he wrote *Fleet Papers*, and later in Queen's Prison.

Oastler was not a Chartist. But he saw far more in Chartism than the six points. To him it was a protest against hunger, misery, and frustration. The immediate need, Oastler thought, was to make Parliament see that there were limits beyond which the impoverished and unemployed could not be driven. Oastler was also a leader in the opposition to the so-called "New Poor Law" after 1834.

This is a very interesting, well-written book about one of the early leaders in the social reform movement.

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BRIEF NOTICES

The Health of the School Child. By GERTRUDE E. CROMWELL, R.N., M.S. Philadelphia and London: W. B. Saunders Co., 1946. Pp. xi+256. $2.50.

This small book presents school-health services from the point of view of the service to the child rather than from that of organization of the program. A brief summary of present knowledge of child growth and development gives a basis for understanding the health needs of the school child. Factors that should be considered in the school environment are discussed in relation to small schools, as well as large ones.

The chapter title, "Using the Findings of the School Medical Appraisal," illustrates the emphasis placed on the end result of benefit to the child rather than on unsolved problems of administration, such as who shall make the health examinations. In the discussions of communicable disease control, health education, and programs for exceptional children, the author gives not only general principles but many practical suggestions. The broad responsibilities of the nurse in the school-health service are well set forth in a chapter that is also helpful on such subjects as the organization of the nursing program and the qualifications that should be required of the school nurse. The last chapter clarifies the relationship of the school-health service and its staff to the school administration and to other departments of the school, as well as community relationships, and suggests ways in which co-operation can be promoted.

Anyone concerned with the planning and administration of a school-health program, or participating in its services, will find this an interesting and helpful book.

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How To Interpret Social Welfare: A Study Course in Public Relations. By HELEN CODY BAKER and MARY SWAIN ROUTZAHN. New York: Russell Sage Foundation, 1947. Pp. 141. $2.50.

Although this is a revised edition of an earlier and well-known book, the present volume is almost entirely new. Even the title has been changed, for the earlier edition was published as *How To Interpret Social Work*. The authors are right in thinking that it is necessary to explain the services of the welfare field and "to point out the routes which lead to broader understanding." The welfare programs are not stationary, and many of the changes and additions in this volume reflect the alterations in the programs of health and welfare work during the past decade. Much more attention is given here to the subject of public relations, and a new chapter on "The Social Agency and Its Publics" is the longest in the book.

After the book was first published, it soon was used as a guide in planning public relations programs. It has also served as a text for students in our professional schools and as a manual for institute leaders or for study courses at various welfare conferences. Supplementing each lesson are questions and projects which should prove stimulating to a class or a group in thinking of additional problems in the experience of its members.

The authors hope that this basic outline will serve as an introduction to other books and pamphlets that deal much more fully with each of the specific techniques.

The present volume is said to attempt to break down "the vast, unwieldy 'public'" into smaller audiences, by "grouping the techniques in three main divisions (spoken words, written words, and pictures) and by proceeding from the simplest and most familiar to the more skilled and formal uses of these three forms of expression." The authors wish to say to the "hopeful but inexperienced builder of public relations": "Here are your tools, and here are suggested ways of using them. With study and practice, may you use them well."

The authors, both well-known experts, have added another useful service to the many services they have already rendered to the field of social work; and many workers and students in social work will appreciate this timely, practical, and attractive volume.

A Psychiatric Primer for the Veteran's Family and Friends. By ALEXANDER G. DUMAS, M.D., and GRACE KEEN. Minneapolis: University of Minnesota Press, 1945. Pp. 214. $2.00.

What can families and friends do to help discharged soldiers on their road back to health when their injuries are of the mind and emotions and nerves? A half-million or more of such men have been discharged from the armed services. *A Psychiatric Primer* answers questions regarding this subject in direct and practical terms. Affection and the best of intentions cannot alone tell one how to deal wisely and effectively with war-torn nerves in a husband, son, friend, or fellow-worker. One needs also intelligent understanding and a sound knowledge that this so-called *Primer* attempts to offers to the families and freinds of returned servicemen.

One of the authors of the *Primer*, Dr. Dumas, a fellow of the American Psychiatric Association, is a veteran of World War I and has served as consultant in neuropsychiatry for a Veterans Administration facility for more than twenty years. Mrs. Keen is apparently a writer of experience in presenting sci-

entific material in readable and understandable form for the layman. Together the authors have produced a very useful and attractive book that should be helpful in the situations it is designed to meet.

Home and Family Life Education in Elementary Schools. By ELIZABETH STEVENSON. New York: John Wiley & Sons, Inc., 1946. Pp. ix+309. $2.75.

This book, one of the results of the author's long experience, describes in practical terms procedures for teaching wholesome personal and family living to the child of elementary school age as a part of his regular study. The position, responsibilities, and problems of the child today are analyzed and his needs considered in relation to the socially desirable objectives of general education.

The book is divided into two parts: Part I, "A New Concept of Home and Family Life Education," which includes chapters on "The Elementary School Situation," "Foundations for the New Proposals," "Kinds of Experiences Which Contribute to the Best Development of the Child," and "How Experiences Develop"; Part II, "Suggested Experiences in Personal, Home, and Family Life," includes eight chapters on such subjects as "Learning To Live, and To Live with Others"; "Food for Pleasure, Health, and Sociability"; "Caring for Younger Children and Convalescents"; "Learning How To Dress"; "Being an Intelligent Consumer"; and other related subjects.

The author believes that important modifications of elementary-school programs are needed today because present programs are not helping children adequately with their personal and home-living problems.

This book should be useful to administrators, educators, supervisors, teachers-in-service, student teachers, parents of school children, and others in school communities who are concerned with extending planned education for better living in elementary schools and in the community. The book is also designed to be helpful in colleges and universities for students of general education and home economics.

Selected readings follow each chapter. The book concludes with an appendix containing illustrative programs, study devices, and teaching aids, and a bibliography.

The Psychology of Adolescence. By KARL C. GARRISON. 3d ed. New York: Prentice-Hall, Inc., 1946. Pp. xx+355. $4.65.

This is a third edition of a well-known text written to include the findings from selected recent studies of adolescents. The author explains that, without sacrificing the major body of facts presented in the earlier editions, he has added much new material relating to the needs of adolescents, the development of attitudes, and various other youth problems of today and tomorrow.

The author's aim in this edition, as in the two previous ones, has been to reach the many college students who are still in the later stages of adolescence and who are "seeking information concerning a multitude of psychological problems, especially personality problems." The book also attempts to give both parents and teachers "a more appreciative view of adolescents and a fuller recognition of the importance of their transition from childhood to adulthood." A further aim of the book is to "introduce the student to basic experimental studies, and thus lay the foundation for a critical appreciation of new studies that are constantly appearing, for the psychology of the various periods of human growth is at this time rapidly developing." The author is associate professor of education and psychology in the Teachers College of Connecticut.

A Long Pull from Stavanger: The Reminiscences of a Norwegian Immigrant. By BIRGER OSLAND. Northfield, Minnesota: Norwegian-American Historical Association, 1945. Pp. viii+263. $2.50.

This volume of reminiscences tells the story of a successful immigrant, a man who pulled away from Stavanger and across the Atlantic to the American Middle West—to Chicago, with its "railroads, factories, and stockyards, mud, smoke, and smells." It is a story with settings in American urban life, ranging beyond the limits of the city on Lake Michigan in which the author, starting with a working capital of six dollars, carved out his business and professional career. Here is a vivid account of Chicago from the late 1880's to the present day, as well as the story of a Norwegian immigrant who became a vigorous American. An officer of the American Army during World War I, he was stationed in Oslo as a military attaché, where he observed the play of world forces in a neutral country.

However, the most interesting part of the book is the eyewitness account of the varied activities and institutions of the author's fellow-Norwegian-Americans through half a century. He records the organizational and institutional affairs of his countrymen through a long period of immigrant transition. The account of the Arne Garborg Club of Chicago in the early 1890's shows the Norwegian-Americans discussing not only the great figures of modern Norwegian literature but also such subjects as democracy, patriotism, labor, romanticism and realism, genius and insanity, John Stuart Mill, and the Negro question.

There is an interesting discussion of the activities of various foreign-born groups in Chicago politics. The author thinks that "the Irish had two decided advantages: a knowledge of the English language and, in spite of personal rivalries, a racial and reli-

gious cohesion which has made them a powerful element in city and county politics." An account of some of the Norwegian-American charitable institutions is especially interesting.

In his later years the author was one of the founders and leaders of the Norwegian-American Historical Association, of which he reviews the beginnings and the development with a sense of the importance of interpreting immigrant forces in American civilization.

This is an interesting autobiography which makes a worth-while contribution to immigration history.

Twentieth Century Sociology. Edited by GEORGES GURVITCH and WILBERT E. MOORE. New York: Philosophical Library, 1945. Pp. 754. $6.00.

This volume, a symposium by a group of distinguished American and foreign sociologists, is said by the editors to have been "undertaken as a venture in stock-taking," and they also report that the symposium "spontaneously and encouragingly reconfirmed the predominant trend of contemporary sociology toward critical but constructive assessment." The emphasis of the contributors is on new problems and positive results—that is, the volume is "not primarily a current history crowded with battles and skirmishes." Differences in emphasis and even in fundamental position are still found in the discussion of the various fields of sociological inquiry, but they are set forth in the spirit of scientific inquiry. Part I includes sixteen papers planned in an attempt to cover most of the special fields in sociology, while the twelve papers in Part II review "the principal tendencies in those countries or regions where the science has been actively developed." The editors note that of course neither section is "complete." "Our aim has not been encyclopedic. We believe however that the coverage is representative, although specialists may perhaps quarrel with the amount of attention accorded to the various recognized fields and areas of sociological research."

This volume will be a valuable reference book.

Human Leadership in Industry: The Challenge of Tomorrow. By SAM A. LEWISOHN. New York: Harper & Bros., 1945. Pp. xiii+112. $2.00.

The author of this little book, now in a second edition, is the president of the Miami Copper Company and the past-president of the American Management Association. He presents what he believes to be certain basic fundamental principles in the improvement of relations between employers and employees, and he has written a book for industrial executives rather than social workers. The author would like to see overemotionalism banished from both sides of labor controversies and the realities of the situation substituted. For example, the question whether it is proper for foremen in plants to affiliate in the unions of employees is, he thinks, not a simple question of workers' rights but what is a sound method of industrial administration. He thinks that capitalism has been made the "whipping boy" and that it is a "naïve simplification" to think of labor issues chiefly as "arising out of struggle between the rich and the poor" (p. 9). The author discusses "The Capitalistic Legend," "The End of the Employer," "Managers of Tomorrow," "Harmonizing Unionism with Industrial Effectiveness," "The New Leadership." The author disclaims attempting an exhaustive or even a symmetrical discussion of any one phase of the subject. He suggests some needed points of emphasis, chiefly concerning the newer problems of industrial relations.

The importance of "inspired leadership in every field—in government, in international affairs, in education, and in economic direction—" is emphasized, and it is suggested that the course for our postwar era will be "determined by the capacity of our leadership in the various areas. We may have depression or high-level consumption, labor strife or co-operation, war or peace, depending upon the wisdom of our leaders."

He thinks the factory is the melting pot of the nation, and "adoption of the right methods of conducting industry and tactful and effective supervision of employees will," he believes, "make the workers appreciate the importance of brains and leadership in our industrial structure."

Government and Politics in the United States. By HAROLD ZINK. Rev. ed. New York: Macmillan Co., 1946. Pp. x+1006. $4.50.

In this revised edition of a standard, well-known text, first published five years ago, the professor of political science in De Pauw University begins with an examination of the national government, proceeds to a consideration of state government, and then provides a rather brief survey of local government to indicate as clearly as possible what services are rendered at these different levels and how the various branches and divisions actually operate at present.

The volume provides a useful background for an examination of the methods of governmental organization and administration in the United States. Believing that "the human element is important in attempting to understand political institutions," the author examines the backgrounds of the executive, administrative, legislative, judicial, and party officials who are in charge of American public affairs.

There are separate chapters on such subjects as "Pressure Groups and Pressure Politics," "The Role of Public Opinion," and "The Obligations of Citizenship." The author has given a larger amount of space than is usual in such texts to the judiciary and to the general problem of public administration, especially

those administrative services that are concerned with public personnel, public revenues and expenditures, foreign relations, and planning.

Social workers will be interested in some of the special chapters such as those dealing with "Public Personnel Administration" (pp. 476–504), "Social Security" (pp. 606–24), and "The Government and Labor" (pp. 590–605).

The Book of the States: Supplement 1947. Chicago: Council of State Governments, 1947. Pp. viii+245. $2.50.

This useful and convenient reference book, recently issued as a supplement to the 1945–46 *Book of the States*, includes primarily a directory of state elective officials and legislators, rosters of state administrative officers, the membership of the Board of Managers of the Council of State Governments, and executive committees of the Council and affiliated organizations.

Certain changes that have been adopted in the publication of *The Book of the States* should be noted. Beginning January 1, 1948, it will be issued biennially in January of even-numbered years, a change which will make possible covering the greater part of legislation enacted by the legislatures of forty-four states which meet in regular sessions during odd-numbered years. Other proposed changes will mean that an up-to-date and extensive coverage of state affairs and state personnel will be available. It may be questioned, incidentally, whether the space given to photographs might not be better used.

Persistent International Issues. Edited by GEORGE B. DE HUSZAR. New York: Harper & Bros., 1947. Pp. 262. $3.00.

This volume comprises a study, by a number of authors, experts in their respective fields, of the many difficult and all-important problems that will remain with us after peace treaties are signed and reconversion tasks practically completed. These problems, if left unsolved, will block the way to real peace, to stability, and to effective international cooperation.

The authors are not very confident that solutions will be forthcoming. Many readers are likely to despair of the civilization the terrible war has all but destroyed in Europe. But some encouraging beginnings have been made. Several new agencies have been set up, and some success in rehabilitation, repatriation, prevention of actual starvation, preservation of life and health in devasted areas, and the like has been achieved. But have we the will and the intelligence required by the colossal tasks facing us in agriculture, industry, trade, finance, transportation, re-education? How many comprehend these tasks and are prepared to do their part? Are we too selfish, too indifferent, too shortsighted for that? What is the lesson of the lamentable failure of America, Britain, Russia, and other powers to make even moderate sacrifices in behalf of the "dislodged persons," so-called?

"Working for peace is hard," says one of the contributors, George B. Shuster, who writes an excellent chapter on education. It is easier to talk of world government in the future than to agree upon and earnestly apply methods and measures involving prolonged co-operation in many fields.

At any rate, this symposium is invaluable to public men and to high-minded citizens who want to know what there is to be done preventively and constructively for enduring peace on the basis of justice and reason and what permanent agencies are needed for the manifold and costly program.

V. S. Y.

The United Nations Economic and Social Council. By HERMAN FINER. ("America Looks Ahead," a Pamphlet Series, No. 12.) Boston: World Peace Foundation, 1946. Pp. 121. $0.25.

This small volume was apparently written in 1945 although not published until the following year. But it is still a very timely account, brief enough to commend it to the general reader, of the place of the Economic and Social Council in the United Nations organization and its relation to various special international agencies. Professor Finer's competent knowledge of the experience of the League of Nations makes it possible for him to relate the new organization to the work of the League. He is right in pointing out the very substantial contribution which the League made to world economic and social development in the interwar years. In a chapter dealing with "World Economic and Social Interdependence," he discusses "controlling ideas"—such as economic welfare and war, the world's loss from poverty, the distribution of population and industry, the distribution of raw materials, and dependence of the national economy on the network of trade. He considers world economic purposes and world agencies and reviews the existing agencies, such as the I.L.O., the F.A.O., and the International Monetary Fund, and the International Bank in relation to the Economic and Social Council and the Assembly. World government, Professor Finer thinks, "implies a world mind, even as a world mind is a condition of world government," but he does not suggest "anything like a superstate or even at this stage a fairly highly organized world federation." He considers that the "incomparable merit" of the General Assembly lies in the fact that it brings all countries together "in one great and frequently meeting forum." The mobilization of public opinion and the definition and establishment of international standards is, he thinks, "the really epoch-making function" ascribed to the General Assembly by the Charter. The Assembly "being above suspicion of an interested party

and with an evident sweep of vision" has the duty of surveying the whole field of economic, social, and humanitarian activities. He sees the special task of the Economic and Social Council in relation to the Assembly above and the specialized agencies below as co-ordination—"preparation of general policies for the Assembly to consider; watchfulness over the activities of the Members and the specialized agencies; and administrative co-ordination of the several specialized agencies."

Professor Finer reminds us that under Article 56 of the Charter "all Members pledge themselves to take joint and separate action in co-operation with the Organization for the achievement of the purposes set forth. . . . ." The life of the United Nations and the Economic and Social Council are, he thinks, "entirely dependent on the fulfilment of this pledge."

There is a bibliography and an appendix containing important articles from the Charter.

Problems of the Postwar World: A Symposium on Postwar Problems. Edited by THOMAS CARSON TOOKE MCCORMICK. New York: McGraw-Hill Book Co., Inc., 1945. Pp. viii+526. $3.75.

This symposium is important from every point of view. It comprises a collection of individual papers carefully prepared by members or former members of the faculty of the University of Wisconsin, which is proud of its tradition of individualism. They all deal with our major postwar problems in a scholarly and scientific spirit. Together they constitute a solid contribution to our understanding of those complex questions of policy and administration. Each of the writers deals with his particular subject in the light of history, recent experience, and present difficulties and maladjustments that require the earnest attention of lawmakers, statesmen, experts, and lay citizens of influence and authority.

Progress already achieved in various fields is duly noted and evaluated. Mistakes are frankly pointed out, and recommendations are submitted for the consideration of those whose responsibility for future intelligent action is direct and recognized.

The remarkable scope of the symposium is indicated by the subjects covered—income and investment, American unionism in the postwar period, social security, agriculture, taxation, planning, local government and democracy, federalism, education, the Negro, international relations. Some of the papers are books in themselves, and it would take a book to do them justice.

There is no attempt to write "journalese." The style is rather academic but not obscure or unnecessarily technical. The "headline reader" will not derive much profit from it, but, if he perseveres and really tries to follow the writer and to grasp his reasoning and conclusions, he will not go unrewarded. Democratic government, after all, does presuppose fairly general appreciation of the magnitude and nature of the problems faced at a given time and the solutions dictated, or at least indicated, by available knowledge and honest, mature thinking.

V. S. Y.

A History of Local Government. By K. B. SMELLIE. ("New Town and County Hall Series," No. 2.) London: George Allen & Unwin, Ltd., 1946. Pp. 192. 7*s*. 6*d*.

This small volume which covers briefly the evolution of modern English local government deals with the political, economic, and scientific factors in this development, particularly since 1832. There is an introductory chapter on the condition of local government between 1689 and 1832.

The services provided by the English local authorities are roughly classified as environmental and personal, the former including the protection of life and property by an efficient police and the planning of streets and open spaces in the interests of safety, health, and even beauty. The personal services include education, the specialized work of the hospitals for accidents and disease, and, in case of need, the help of the social welfare department. The line between environmental and personal services is not rigid.

Modern English local government was established to deal with the problems which arose in the middle of the eighteenth century when the use of machinery began to shape the modern world. The ideas which since the Reform Bill of 1832 have determined the nature of local government were first tried out in experiments initiated in the old system of the eighteenth century. There is an interesting account of the effect of the so-called industrial revolution on local government and the way in which the changing social and industrial conditions affected different areas.

The Poor Law Act of 1834 was important in determining certain principles of central control of local authorities until 1929. The Municipal Corporations Act of 1835 inaugurated a system of local government by elected councils; the Local Government Act of 1888 applied to the counties the principles of local self-government which had been developed by the boroughs after 1835. But this structure of town and county government has since 1888 been adapted without fundamental change, to those revolutions in science and industry, in public finance and public administration which have shaped the pattern of the present day. There is a separate chapter on London government. Three chapters deal with "the response to new conditions" during the period 1929–45.

The Mass Psychology of Fascism. By WILHELM REICH. Translated from the German manuscript by THEODORE P. WOLFE. 3d rev. & enl. ed. New York: Orgone Institute Press, 1946. Pp. xxiv+344. $4.50.

To review this work adequately, with justice to the author, the subject, and the readers of this periodical, is not possible within present space limitations; and only the thesis of the book and its main conclusion can be briefly indicated, without attempting criticism.

The author asserts that "fascism is the sum total of all the *irrational* reactions of the *average* human character." Every race or ethnic group has its Fascists, actual and potential. Nowhere are the people capable of self-government, and hence nowhere is there any solid, permanent basis for tolerant democracy and liberty. Marxism has never understood or accepted this all-important truth. Freud has, but in his turn Freud failed to offer a complete solution of our crucial social problem. The solution of that problem will include "sex-economic" reforms of a revolutionary sort. A normal sex life is the most essential condition of the truly good society, and this applies not only to the adult population but to adolescents and children also. "Sexual misery" is responsible for racism, for mob violence, for the worship of neurotic dictators, quacks, and hate-ridden demagogues.

In the words of the author: "If human society were organized rationally, love, work and knowledge would, as a matter of course, take precedence over the institutions which are not vitally necessary. The state would actually wither away, the politicians would lose their occupations, and the masses would become healthy, sane, and free from superstition and fear. Sex education and birth control are among the means that will enable us to attain our goal."

For full elucidation of his thesis the reader is referred to other works of the author which deal more technically and elaborately with love, marriage, sex, and related questions.

V. S. Y.

Soviet Philosophy: A Study of Theory and Practice. By JOHN SOMERVILLE. New York: Philosophical Library, 1946. Pp. xi+269. $3.75.

To the making of many books on Russia, its so-called Communist regime and its actual way of life, there is no end. Most of the books are superficial-one-sided, and of little value to the thoughtful and fair-minded public. Professor Somerville of Columbia University has given us a very different sort of book and one of real significance. He went to Russia, having first learned its language, lived there two years, studied Russian history and institutions, talked with many scientists and officials, put to these, as to others, "leading questions"; and the result, now before us, is an account of the philosophic ideas and principles that are basic to the Soviet regime, as well as their effects upon practice.

The work is as free from bias as is humanly possible. The author was not without sympathy with the regime, but he is not a Communist or a fellow-traveler. He does not accept the philosophy which he expounds, though he has been accused of virtual approval of it, at least in part. He states that not all the answers he elicited from the Russian intellectuals were satisfactory to his mind, but they were all frank and sincere—of that he has no doubt.

The Soviet philosophy is of course Marxist—with reservations taught by experience. Stalin has said that "life has a logic of its own," and dialectical materialism is not always on all fours with it. Most of the Russian intellectuals try to remain faithful to what they believe to be essential in Marxian socialism or dialectics. They debate the subtler issues of that philosophy at annual conferences and in scientific magazines. But unanimity is never achieved.

Professor Somerville discusses most of the issues which need more light and less heat than we are getting from other writers—soviet politics and diplomacy, soviet definitions of democracy and freedom, soviet art and ethics, etc. To repeat, he elucidates. He presents the Russian point of view, not his own. He does not apologize or dodge embarrassing points.

College classes and discussion groups should welcome his notable contribution to the controversial Russian problem. The prejudiced doctrinaires and bitter ex-Communists who play into the hands of reaction and obscurantism by reckless repetitions of malicious falsehoods or wild exaggerations will not recommend the book to truth-seeking readers.

VICTOR S. YARROS

La Jolla, California

REVIEWS OF GOVERNMENT REPORTS AND PUBLIC DOCUMENTS

Nutrition in Industry. INTERNATIONAL LABOUR OFFICE. ("Studies and Reports," New Series, No. 4.) Montreal, 1946. Pp. 177. $1.50.

This is a report in three parts, each by a separate author, describing the steps taken in Canada, the United States, and Great Britain to safeguard and improve the nutrition of industrial workers during the war. The steps taken were the encouragement or requirement of adequate arrangements for what in the United States is called "in-plant feeding," in Great Britain, "industrial canteens," and nutritional education of a popular character by a variety of methods.

In Canada as a part of a health conservation program for workers in war industries the Division of Nutrition of the Department of National Health inspected food facilities in plants and recommended changes when necessary. In the United States advice and assistance in improving industrial food services were furnished mainly by the War Food Administration. In Great Britain the establishment of canteens for the provision of hot meals was made mandatory by successive orders that finally covered practically all workers in factories, on docks and on building-sites. An easy method was thus provided for supplementing the ration as the character of the work seemed to require.

Three conclusions emerge from these reports. One is that satisfactory working conditions include easily accessible food services providing food of good quality in clean, restful, pleasant surroundings; the second, that in the words of the author of the American report, "In-plant feeding is only a part of the answer to the nutritional problems of industrial workers and, since the majority of all workers never did patronize in-plant feeding facilities regularly for complete meals and probably never will do so, and since most of those who do use them regularly depend on them for only one meal a day, it is a minor part." The third is that the wartime growth in communal feeding is by no means a permanent change in consumption pattern. "Most of those concerned in Great Britain appear to hold this conviction strongly," says the British report.

HAZEL KYRK

University of Chicago

WRA: A Story of Human Conservation. UNITED STATES DEPARTMENT OF THE INTERIOR, WAR RELOCATION AUTHORITY. Washington, D.C.: U.S. Government Printing Office, 1947. Pp. xvi+212. $0.55.

The evacuation of the population of Japanese descent from the West Coast in 1942 has been one of the severest challenges to our democratic principles of government and without parallel in the history of this country. It is not surprising, therefore, that, among many other citizens, social workers voiced their serious concern about this unprecedented, deplorable treatment of more than 120,000 human beings, including over 70,000 American citizens. A substantial number of books and articles in professional journals, including this *Review*, have discussed the various aspects of the evacuation and relocation; and the underlying economic, political, and social motivations have been often analyzed. The War Relocation Authority, after the closure of the last of the ten relocation centers in 1946, decided to report to the people on the operation of the agency. Nine special publications describe the experiences of the agency in the internment and the relocation of the Japanese Americans during 1942 to 1946. The final report, *WRA: A Story of Human Conservation*, presents a brief and comprehensive survey of the entire W.R.A program. It begins with a chronology of the events and an analysis of the agency and its "clients." We learn of the hostility to the Japanese-Americans on the West Coast, particularly in California, and the rather vicious campaign of influential newspapers and pressure groups eager to get rid of the competition of the Japanese-Americans. Their effect on the President and the military authorities and federal and state agencies is candidly analyzed. The book

describes the setup of the relocation centers, the methods used in the evacuation and internment, and later the program for the transfer of as many evacuees as possible to communities outside of the prohibited West Coast. The serious difficulties in this process are admitted, mistakes acknowledged, and the principles explained. The book analyzes the crises, incidents, mutinies, and disturbances which the relocation centers experienced. The problems of the management of the centers under serious handicaps and the incessant fight which W.R.A. carried on in order to regain for the Japanese-Americans their places within the American community are well explained. The segregation of the so-called "disloyal" group of the evacuees at Tule Lake in northern California made it possible to secure for the other nine relocation centers an intensive out-placement program. The difficulties in the administration of the centers were increased by the resettlement of the most energetic, skilled, and best-adjusted evacuees, so that the self-government in the centers and the labor forces were impaired. Another serious problem was the maintenance of law and order. The War Relocation Authority had first hoped that the evacuees themselves would be able to organize their internal security at the centers, but the practice proved that the establishment of a police force under the Authority was necessary. In general, the crime record of the centers remained only one-third that of average communities of the same size. But the residents were "a psychologically bruised, badly puzzled, and frequently apathetic group of people" who tried to achieve some order in their broken lives. Particular difficulties arose among the adolescents in the centers. They found their former belief in authority of parents and government suddenly shattered, and they often formed gangs to terrify informers or other evacuees suspected of being too close to the administration. The only solution to these behavior patterns was the removal of the youngsters with their families to ordinary communities. The program of carrying out this plan was consistently pursued by the administration and was greatly furthered by the spectacular record which the Japanese-American combat units made in their fight in the European war. W.R.A. had been instrumental in winning the consent of the War Department for the recruitment of these units in order to regain the respect of the people for the evacuees. The resettlement of the evacuees was finally carried out with the aid of field offices in Chicago, New York, Denver, Salt Lake City, Cleveland, Kansas City, and Little Rock. They were effectively supported by local resettlement committees in which representatives of the Federal Council of Churches of Christ, of the Y.M.C.A. and the Y.W.C.A., and of the American Friends Service Committee played an important role. Social workers will understand the difficulties that the Authority again encountered when it stressed the need for the closure of all centers and the resettlement of all residents in either their old or in new communities. The danger of the desire to remain in the "security" of the center with its regular food and other living accommodations was evident, a typical characteristic of institutionalization. The W.R.A. showed in this report that it made an effort not to keep the evacuee group in the centers any longer than was absolutely required, so that their self-reliance was not too seriously affected and before they became real "wards of the Government."

The book emphasizes the democratic nature of the organization of the War Relocation Authority, its intensive staff participation in policy-making, and its careful advance planning. As suggestions for the future treatment of the Japanese-American minority the report makes three recommendations: (1) the establishment of an "Evacuation Claims Commission" for a compensation of property losses in this process, (2) inclusion of the Japanese into the naturalization quota, and (3) continuation of local citizens' committees to aid in the adjustment and reintegration of the returned or resettled evacuees.

The result of the relocation process has been that about fifty-four thousand of Japanese descent who had been living on the Pacific Coast are now spread over the entire country (with the exception of South Carolina). Nearly one-half of all evacuees have returned to their old homes at the West Coast, mainly to California. The book concludes with the optimistic note that, while there is a marked xenophobic tendency in this country, there also is "a strong and stubborn potential for fair-mindedness among the American people" that should be fostered in the interest of greater racial tolerance and a richer realization of democratic values. The book is recommended for schools of social work and for the serious study of all social workers.

WALTER A. FRIEDLANDER

University of California, Berkeley

Issues in Social Security: House Report, Seventy-ninth Congress, First Session. Washington, D.C.: U.S. Government Printing Office, 1946. Pp. xviii+742.

On March 26, 1945, House Resolution 204 provided funds to enable the Committee on Ways and Means to obtain information with respect to the need for the amendment and expansion of the Social Security Act. The result was that a social security technical staff was created to make an investigation and to report on old age and survivors insurance, unemployment compensation, and public assistance. This *Report*, published the following year under the title *Issues in Social Security*, is rich in information about the more significant aspects of old age and survivors insurance (including extended disability), old age assistance, aid to dependent children, aid to the blind, general assistance, and unemployment compensation.

The *Report* makes clear that it deals with only a part (a very important part) of the social security program. Social security, in the broader sense, includes public health, vocational rehabilitation, maternal and child welfare services, medical care, hospitalization, cash sickness benefits, and cash maternity benefits, all of which are outside the scope of this *Report*. In spite of this limitation, the *Report* is one of the best single sources of information obtainable about the public assistance and social insurance programs within its compass. It describes each of these programs; reviews the proposed changes in each; and evaluates the purpose, effect, and cost of such changes. This *Report* is a valuable source of information because of its comprehensiveness, its clear style, its detailed Index, and its helpful charts and tables. It includes over 230 tables on various aspects of the two insurance and four assistance programs discussed.

The Introduction considers briefly the evolution of social security programs and their present and future status. Part I of the *Report* covers old age and survivors insurance. Its six chapters include a discussion of the development and present provisions of this insurance and the needed improvements such as extended coverage, liberalized benefits, and sounder financing. Part II, on public assistance, includes such subjects as federal participation in public assistance; adequacy of assistance payments; maximum grants; variable grants to states; equitable distribution of funds within states; adjustment of eligibility requirements; and extension of aid to needy persons not now covered. Part III describes and evaluates the present federal-state system of unemployment compensation, including coverage, benefit structure, administration, and financing. It discusses basic changes in the present system, such as complete federalization or a complete state system, as well as modifications in the present federal-state system possible through such a device as federal grants-in-aid to the states.

The *Report* is notable for its presentation of both sides of controversial questions and for its inclusion of closely related material in illuminating aspects of the program under discussion. Significant material is presented in several appendixes. For example, the appendixes to Part II (public assistance) include the public assistance provisions of the Social Security Act; a summary of experience since 1935 with the categorical programs; the recommendations of the Social Security Board and other groups for improving medical care provided under public assistance; the methods now used by the states for providing for medical care; recommendations and findings of selected groups and agencies regarding residence and settlement laws; and an outline of recent bills relative to public assistance. The appendixes for Part III (unemployment compensation) are equally valuable.

A general appendix on living costs reveals the intimate relation of living costs to the benefit provisions of social security programs, since living costs determine the quantity of goods and services which a given amount of social security benefits will buy. The matter of living costs is considered from three points of view: (1) changes over a period of time; (2) differences between various cities and sections; (3) the cost of a specified standard of living.

Although the reader may not agree with all the conclusions, he will be impressed by the thorough work of the committee in compiling and analyzing this material. In the absence of a good modern text on social security, this *Report* is a highly valuable compilation and evaluation of the most important issues in this field and will remain one of the best sources of information on the two basic income maintenance programs of social insurance and public assistance.

MARY SYDNEY BRANCH

University of Chicago

Social Security Yearbook, 1945: Annual Supplement to the Social Security Bulletin. Federal Security Agency, Social Security Administration. Washington, D.C.: U.S. Government Printing Office, 1946. Pp. ii+182. $0.75.

This volume, the seventh in the series of annual supplements to the Social Security Administration's monthly *Social Security Bulletin*, maintains the same high standards of clarity and usefulness set by its predecessors, beginning with the first in 1939. Whereas the *Bulletin* contains valuable current monthly data on the operation of the several social security programs and related matters, the *Yearbook* analyzes and discusses these materials for a twelve-month period.

The reader will find few changes in organization and plan of this report over that of 1944. The *Yearbook* opens with a chronology of "significant events and developments" in social security in 1945, followed by sections on "Social Security and the National Economy," "Old Age and Survivors Insurance," "Unemployment Insurance," "Public Assistance," and a list of recent publications of the Social Security Board. The volume is indexed and contains a useful classified list of the 160 tables scattered throughout the report.

Among the interesting facts found in this *Yearbook* are that the $2.9 billion paid in allowances to dependents of servicemen in 1945 equaled all the payments under social insurance and related programs, including payments to veterans, and amounted to three times the total spent for public assistance. Total expenditures for social security and related purposes amounted to $4.6 billion in the fiscal year ending June 30, 1945—slightly more than one-half of which came from federal funds; about one-half of these payments was for social insurance and related programs, one-fourth for health and medical services, and less than one-fourth for public assistance. The federal contribution to these payments amounted to $7.00 in each $10.00 spent for social insurance, $4.00 in $10.00 for public assistance, and $3.00 in $10.00 for health and medical services.

There is considerably more space allocated to "Old Age and Survivors Insurance" and "Unemployment Compensation" than to "Public Assistance," only 21 of the 182 pages being given to the public aid programs. The public assistance data presented are mostly of the conventional sort, and most of it could be obtained from the monthly *Bulletin*. With respect to general relief, where the need for overhauling and strengthening the program is most urgent, the report contains but one summary table showing the monthly expenditures by states. Although the Social Security Board (and the Social Security Administration, which replaced it in July, 1946) has consistently recommended federal grants-in-aid for general relief, it has never assembled and published facts about this program that would reveal just how deficient it is. One could read this present report, as well as other publications of the federal agency, without discovering that there are considerable areas of several states where there is no provision whatever for aiding persons who do not fit into one of the three categories for which federal grants are available. In like manner this report, as well as other publications of the federal agency, do not reveal the chaotic condition of medical services for dependent persons in many of the states. If the Social Security Administration would turn the "spotlight" on these two areas of greatest need, it would do much to bring about long overdue changes in these programs.

Withal, every student of social security will wish to add the 1945 *Yearbook* to his library. It is packed with facts and analyses that he cannot find elsewhere in so convenient and useable form.

A. A. L.

A Report of Specialized Public Services for Children in Oregon for the Biennial Periods July 1, 1942 to June 30, 1944 and July 1, 1944 to June 30, 1946. STATE PUBLIC WELFARE COMMISSION. Portland, 1947. Pp. 105.

The State Public Welfare Commission of Oregon has published a double report, which is called *Specialized Public Services for Children* and in which it has provided information covering two biennial periods.

The statistical material for each part of the *Report* is preceded by brief statements discussing the special services to children, including child welfare services; day care of children; State Advisory Committee on Child Care, Health, and Welfare; certification of private child-caring agencies and institutions; state aid; county aid; foster-home certification; interstate

placement of children; adoption; and services to Crippled Children's Division.

It is interesting to note that there has been recognition of the absence of some of the safeguards for adoption recommended by the United States Children's Bureau, and it is suggested that there should be a careful review of adoption statutes and procedures by a representative, widely selected state-wide group to consider revisions which will incorporate into the law essential provisions to provide social and legal safeguards for the child, the parents, the adoptive parents, and the state. In Oregon the adoption rate is high, and it is easily understandable why there should be a desire to see to it that every important safeguard is provided.

MARY RUTH COLBY

Minneapolis, Minnesota

Iowa Department of Social Welfare, Report for 1945–1946. DIVISION OF RESEARCH AND STATISTICS, STATE BOARD OF SOCIAL WELFARE. Des Moines, 1947. Pp. 69.

The number of recipients receiving public assistance in Iowa increased gradually up to the latter months of 1941. Since that date the number has shown a steady decrease. On the other hand, appropriations for assistance have continued to increase, making possible larger individual grants.

During the fiscal year 1945–46 the maximum grant in the aid to dependent children's program was $18 for the first child and $12 for each succeeding child, with a total maximum of $75 per family. On June 30, 1946, there were approximately 80 per cent of the families receiving maximum grants. The average size family was approximately 3.5 persons, and the average grant, as of June, 1946, amounted to $33.86. This amount can be contrasted with the average of $33.96 paid to a single old age assistance recipient. A large number of A.D.C. cases had to look to county relief funds for supplementation. It should be pointed out that since this *Report* was published all maximums in A.D.C. have been removed in Iowa, and grants are now given on a needs basis.

The *Report* refers to some of the continuing problems such as the need for adequate nursing-home care for old age recipients and the difficulties arising from continued state control of approvals for old age assistance grants making for delay in the acceptance of pending applications. The lack of availability of specialized and trained personnel continues to be a problem. The situation is particularly acute in the child welfare program, which is very much handicapped owing to the lack of workers trained in dealing with problems relating to children. As of June 30, 1946, there were only fifteen child welfare workers assigned in the ninety-nine counties to provide direct service to certain local areas and only six workers assigned to special projects. The personnel situation might be relieved somewhat if Iowa could free itself from its residence requirement for workers.

From the very brief *Report* it would seem that much of the activity of county departments and the state department is limited to determining eligibility and a redetermination of continued need. There is little given regarding the child welfare program as a whole, the service program of the agency, or the department's thinking regarding its problems, its progress, and its plans and objectives for the future.

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Missouri State Social Security Commission, Annual Report for 1945–1946. ("Index of Public Assistance in Missouri," Vol. IX, No. 4.) Jefferson City, 1947. Pp. 177–240.

This *Report* covers the last year of the State Social Security Commission, which became part of the Division of Welfare of the State Department of Public Health and Welfare on July 1, 1946. The new department was established following the adoption of Missouri's Constitution of 1945. This *Report* has been made on the fiscal year basis as now required, whereas earlier reports used the calendar year.

Two "major events" of the year are noted, both of which affected trends and costs of state public assistance programs. One was the end of the war and the other was the legislation of July, 1945, which set a new maximum of $40 for an individual old age assistance grant as compared with former maximums of $30 for an individual and $45 for a husband and wife living together and both eligible for assistance. The former $60 limitation on aid to dependent children for children living in one household was also re-

moved. This benefited families with five or more children eligible for this type of aid.

The number of recipients of O.A.A., which had decreased each month since December, 1941, showed some increase each month of the year after the war. Recipients of A.D.C. also began to show substantial increases throughout the year. The number of recipients of general relief was limited by funds made available for this program and in turn by the proportion of needs which could be met. The general relief situation seems to have been very unsatisfactory. The program has been financed largely from state funds, with a limited amount of local funds in some counties. The policy of limiting relief to unemployable persons and families continued. An unemployable person is, by definition, one who is unable to work. The policy seems to have been that the presence in a family group of one person who is able to work rendered the entire family ineligible for relief. Single persons are not eligible to receive relief if they are receiving any other type of assistance. Family groups, on the other hand, are not disqualified from receiving relief if one or more but not all members of the family receive another type of assistance which fails to provide the amount of assistance the family would be granted if they were receiving relief only. There are,therefore, families receiving relief in which there are children eligible for and receiving A.D.C. and a few families in which there is one person receiving an O.A.A. grant.

Because of the limited funds available for relief, the *Report* acknowledges that it had not been possible to provide any family with sufficient assistance to meet its total needs. An attempt was made to determine the total necessary expenses of the family, reducing these by a percentage amount and then deducting the income or assistance from other sources which the family might receive from the computed percentage of its total necessary expenses. From June, 1945, until February, 1946, relief cases received 65 per cent of their necessary expenses less whatever income the individual case might have. In March, 1946, it was necessary to reduce the proportion from 65 to 55 per cent of expenses less the total income. It is clear that relief is still an unsolved problem in many areas.

There are also sections of the *Report* that deal with legislation, a review of the individual welfare programs, a review of administrative services, and a summary of expenditures and sources of funds. As this is the commission's last annual report, an attempt has been made in both the text and the Appendixes to include more material regarding the agency than had been customary.

E. A.

Public Welfare in Oregon, July 1, 1945—June 30, 1946. By the STATE PUBLIC WELFARE COMMISSION. Portland, Oregon, 1946. Pp. 52.

The State Public Welfare Commission of Oregon goes back to the state relief program of 1933. The State Relief Committee later became the State Public Welfare Commission and was authorized by the legislature to administer certain public welfare services that received state aid—old age assistance, aid to dependent children, aid to the blind, general assistance, medical care, and child welfare services. The seven members of the state commission are appointed by the governor for overlapping terms of four years each and seem to be frequently reappointed for additional terms. The commission selects its own chairman and secretary. The commission serves as the "single State agency" to set standards for the public assistance programs and to "secure uniform observance of these standards throughout the State." County public welfare commissions, which like the state commission consist of seven members in each county, administer public assistance in the counties subject to the rules and regulations of the state commission

The *Report* suggests that the year 1945–46 may be regarded as falling within the reconversion period. "Unemployment compensation plans, medical care, the extension of benefits by various social measures to veterans and their dependents, as well as changes in the Social Security Act, were all given a measure of Congressional attention," but the much-desired changes in the federal Social Security law were postponed.

The monthly statistical report "Public Welfare in Oregon" has been revised, procedures for setting up newly instituted reports completed, and several new projects undertaken during the year, including (1) reasons for opening cases approved for financial assistance, (2) characteristics of children receiving services for public institutions, (3) children coming to the attention of the juvenile courts, (4) adoptions for the

calendar year 1944–45, and (5) medical care in selected counties.

While an attempt is made to maintain a close working relationship between state and county public welfare departments by means of the supervisory-consultative field service to county departments in relation to public assistance programs, this service could only be extended on an emergency basis because of the shortage of staff. Special field services included participation in the federal administrative review and a medical care survey.

Support for public assistance seemed to be met by funds from federal, state, and county sources, with the federal government paying 34.2 per cent in 1946, the state 46.6 per cent, and the counties 19.2 per cent. State funds come mainly from liquor revenues and from the state's portion of the receipts from the tax on amusements; county funds from a tax levy on real property and the county's portion of state taxes on liquor revenues and amusements. The child welfare services program is supported through a federal allocation, plus a supplementary pro rata contribution. State subsidies to private agencies and institutions for the care of dependent and wayward children and venereal and maternity patients are met entirely from state funds through a special biennial appropriation. The Oregon policy is to subsidize the private child-caring institutions and agencies, and these subsidies came to $170,597 in the year reviewed.

A Civil Service Act was passed in 1945, and the employees of state and county public welfare commissions were, as previously, covered by a merit system. The act of 1945 provided that the Merit System Council was to continue during the organizational period of the Civil Service Commission. The act is expected to provide for a state-wide system of personnel administration based on "merit principles and scientific methods governing the appointment, protection, transfer, lay-off, removal, and discipline of its officers and employees, and other instances of state employment." But the first year of the Civil Service Commission's operation was concerned largely with organization and the development of rules, classification, and compensation plans.

In June, 1946, Oregon's average O.A.A. grant was $39.53. Only six other states had higher average grants than Oregon that month, with Washington the highest, with an average grant of $53.53, and California second, with an average of $47.66. An amendment to the O.A.A. Act of 1945 removing the $40 maximum for old age assistance grants brought the percentage of grants in excess of $40 from 11.4 per cent in June, 1945, to 32.9 per cent in June, 1946.

The general assistance program provides assistance and/or services to needy persons not otherwise provided for, including household consumption items; care of children in foster-homes; medical, surgical, and hospital care; and cost of burial. Payments are provided "according to the extent of need and the availability of funds."

All persons who are in need are eligible for aid from general assistance funds. This includes those who are not able to meet the age and residence requirements of the Social Security program, as well as those who are in need while the establishment of their eligibility for a Social Security grant is being completed. Under the general assistance program assistance is given to all needy persons without respect to age, marital status, or residence.

General assistance funds are also used to supplement O.A.A, A.B., and A.D.C. payments for medical care whenever such costs cannot be anticipated and provided for in the grant. Medical costs now being included in O.A.A grants are said to explain the decrease in the number of supplementary cash grants for medical care from 562 grants ($13,768) in June, 1945, to 43 grants ($1,150) in June, 1946.

There is a section dealing with child welfare, including reports on child welfare services, foster-home certification, certification of private child-caring agencies and institutions, and state aid, which discussed the per capita subsidy for the support of children under the care of the private child-caring agencies and institutions, a discussion of adoptions, of interstate placement of children, of crippled children's services, and of the State Advisory Committee on Child Care, Health, and Welfare.

On the State of the Public Health during Six Years of War: Report of the Chief Medical Officer of the Ministry of Health, 1939–45. London: H.M. Stationery Office, 1946. Pp. iv+280. 5s.

This is "no ordinary Annual Report covering a single year of peace." It is an authoritative

account of the state of public health and of the medical work of the Ministry of Health "during the trials, the mercies, the efforts and the final triumphs" of six years of unprecedented strain.

There are divisions of the *Report* dealing with "Vital Statistics"; "General Epidemiology"; "Maternity and Child Welfare"; "Food and Nutrition," including rationing; "Emergency Medical Service"; "Civil Defence Casualty Service"; "Problems of Medical Man-Power"; "The Nursing Services"; "Morbidity Statistics"; and a few other subjects. The new services and the extension of existing services to meet the needs intensified by total war are not overlooked. A section on "Health Publicity" notes that the experience of the war years proved the value of mass publicity methods in supplementing personal instruction on health matters. These methods, it is pointed out, had been "successfully used in the United States for some years." A review of the field of health education and its relation to preventive medicine is now being undertaken.

Some of the vital statistics of the war years are significant and on the whole are "phenomenally good." Infant mortality, which was 50.6 in 1939, met a setback in the next two years but declined to 49.1 in 1943 and to 45.4 in 1944. Systematic mass immunization for diphtheria which was to have begun in 1940 was delayed until 1942. In 1940 there were 46,281 diphtheria cases with 2,460 deaths, and for 1944 there were 29,949 cases with 934 deaths "despite all the adverse circumstances of war."

Fears of influenza during the war fortunately proved false. In six winters, three of which were severe, two short epidemics of influenza occurred, both of comparatively mild type. With regard to tuberculosis it is pointed out that after an increase of nearly 11 per cent from all forms of tuberculosis during the years 1940 and 1941, the pre-war level was resumed in 1942 and 1943, with a further decline in 1944 to 95 per cent of the pre-war level.

Wartime conditions in England and Wales favored the spread of venereal disease from 1939 to 1945 far more than in the years 1914–18, and the venereal rates rose to a figure never previously reached in Great Britain.

There is an account of the "Evacuation of School Children and Others," i.e., young children accompanied by their mothers, expectant mothers, and other classes such as blind persons and cripples. Plans were made for the voluntary evacuation of some three million persons, and 1,270,000 persons took advantage of the official scheme. Of these, 734,883 were school children "unaccompanied"; 260,300 were young children "accompanied" by 166,200 mothers and other adults; 12,291 were expectant mothers; and some 5,000 were blind or crippled persons; the rest were teachers and helpers; foreign refugees; evacuees from Gibraltar; refugees from the Channel Islands, from Norway; children from Holland. The conditions which followed evacuation and the "general fear expressed by press and public in the late autumn of 1940, when the air raid shelters were seriously overcrowded" led to newspaper and radio publicity about the efforts to improve conditions in the shelters, about the educational work of the doctors and nurses attached to medical aid posts, and the advice on health given to those who used the shelters. "The country began to realise that germs might be as dangerous as Germans."

There are interesting brief sections on "International Health and Medical Intelligence" and "Environmental Hygiene"—the latter dealing with the new factories, air stations, and hospitals. The recruitment of thousands of laborers from all parts of the country to work on construction plans led to various problems in the camps where thousands of men were congregated. The contractors learned that good work with a minimum loss of time meant decent living conditions. The officers of the Ministry of Health worked with the factory inspectors in advising the contractors with regard to welfare services for their workers.

A final brief section, "Planning for the Future," deals with "A National Health Service," —with the White Paper (Cmd. 6502) of 1944, the hospital surveys, and the Interdepartmental Committee on Medical Schools.

This is an interesting account of the "unexampled state of public health" during a long war; and large numbers of devoted workers, medical officers of health, general practitioners, and nurses, as well as civil servants, deserve great credit for the results.

E. A.

Final Report of the Committee on Procedure in Matrimonial Causes. (Cmd. 7024.) London: H.M. Stationery Office, 1947. Pp. 37. 9*d*.

While this *Report* deals with some technical questions regarding the English courts—particularly with regard to the custody of children —the Divorce Division, the Chancery Divi-

sion of the High Court, the magistrates courts, and the county courts, it should be useful to family welfare societies because of its discussion of the importance of social service. The subjects dealt with include reconciliation; children and divorce; alimony, maintenance, etc.; and various procedural reforms.

The *Report* refers to the work of the Marriage Guidance Council[1] as the "most striking civilian development in recent times." The work of the "marriage guidance centres" in London and in the provinces is discussed in some detail.

One of the general conclusions of the *Report* is that the reconciliation of estranged parties to marriage is of "the utmost importance to the State as well as to the parties and their children. It is indeed so important that the State itself should do all it can to assist reconciliation."

Another recommendation is that the pattern for reconciliation "has been set by the work done by Probation Officers, the Welfare Services and Legal Aid Sections of the Forces, the Marriage Guidance Council, the Family Welfare Association and many other voluntary societies and individuals." The success of these agencies is said to have been such as "to justify the conclusion that means for reconciliation should be made available both before and after divorce proceedings have been commenced." However, it is pointed out that there is "much less chance of reconciliation after a suit has been started."

A third recommendation is that there should be a Marriage Welfare Service "to afford help and guidance both in preparation for marriage and also in difficulties after marriage. It should be sponsored by the State but should not be a State institution." It is suggested that this service should "evolve gradually from the existing service and societies just as the probation system evolved from the Court Missionaries and the Child Guidance Service from the children's clinics." The *Report* does not think that this service should be combined with judicial procedure for divorce but should function quite separately from it.

The principal aims of the Marriage Welfare Service are outlined as follows: (1) to make available a sufficient number of suitable persons to give advice and to see that their availability is generally known; (2) to encourage young people to seek competent advice in preparation for marriage; (3) to encourage married couples to seek competent advice as soon as serious conflicts arise; (4) to attempt reconciliation whenever a break has occurred.

The *Report* not only emphasizes the importance of voluntary service but recommends a grant-in-aid to the "voluntary organisations which work in the field of marriage guidance and which like most similar organisations depend on voluntary subscriptions and are hampered by lack of funds." Although "grants in aid of societies working in the field of marriage guidance" are recommended as desirable "in cases when a society has proved the value of its work to the State," the *Report* points out that the application of this principle in individual cases is an administrative matter which must be left to the judgment of the Minister concerned.

A further recommendation is that carefully selected welfare officers should be appointed "to give guidance to parties who resort to the Divorce Court or are contemplating doing so." The aim should be to appoint men and women of such "education, sympathy and understanding as to be able to obtain the confidence of persons in all sections of the community." The *Report* also recommends that these welfare officers "should be trained in social service, particularly in marriage guidance and the welfare of children; and they should be given courses of instruction including refresher courses in these subjects." However, in order to make a prompt beginning it is recommended that the first court welfare officers could be appointed from among the probation officers, and it is also suggested that the new service might even be developed from the existing probation service.

E. A.

[1] This is a voluntary organization registered as a charity, which was organized in 1938; see this *Review*, XXI (September, 1947), 410–11.

Community Centres. Issued by the MINISTRY OF EDUCATION. London: H.M. Stationery Office, 1945. Pp. 40. 9*d*.

This report, which deals with the organization, planning, and management of community centers, indicates public interest in the provision of such centers "to promote the social and physical training and recreation of the community." This may be said to come within the scope of the education service administered by local education authorities through the Education Act of 1944.

It is pointed out that "men and women do not

as a rule make the best of their leisure if the only facilities available outside the home are those provided by commercial enterprise." The provision for other social and recreative activities by voluntary sources is "generally agreed" to be "wholly inadequate," and voluntary effort is said to be quite incapable of meeting the need.

Two points are emphasized—(1) the acute shortage frequently existing, of suitable premises where people can meet to carry on social, educational, and recreational activities. Leisure-time activities usually demand the association of those interested in them, and many of the most beneficial cannot be carried on without such facilities as halls, stages, lecture-rooms. (2) The difficulty experienced in making the existing centers self-supporting. Many fail through lack of funds while others devote too much of their resources to "promoting dances, whist drives and raffles in order to produce revenue."

It is recommended that the provision of premises and facilities for the use of leisure should be regarded as a necessary and important part of the educational system and that a large-scale postwar development of community centers, particularly on new housing estates, is necessary.

It is suggested that provision for a village hall should be made in all villages with a population exceeding four hundred and that youth centers should be closely linked with community centers so that they may conveniently share parts of the same building but the independence of both be preserved.

Local education authorities are urged to undertake a survey of their areas; and when providing community centers, they should explore the possibility of making use of (1) existing or new secondary school buildings and (2) colleges of further education, including county colleges.

It is recommended that housing authorities should retain their powers of providing community centers but that these should be exercised in consultation with the local education authorities concerned. The latter should be generally responsible for meeting the cost of the buildings and their structural maintenance and the warden's salary.

It is hoped that the experience of the war years, which after September, 1939, brought large groups of men and women of all ages and from every level of society into various forms of community life, in the armed and civil defense forces, in war-worker's hostels, and in the wide variety of organizations fostered by the youth service, may mean that many of them will be glad to "apply the technique of social living which they have acquired in war to the enrichment of their own and their neighbors' lives in peace."

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The University of Chicago

SCHOOL OF SOCIAL SERVICE ADMINISTRATION

ACADEMIC YEAR 1947-48

Winter Quarter begins January 5, 1948

Spring Quarter begins March 29, 1948

SUMMER QUARTER—1948

(Dates to be announced later)

Announcements

GIVING COMPLETE PROGRAM AND REQUIREMENTS FOR ADMISSION WILL BE SENT ON REQUEST.